

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

**BARRY RANDALL THOMAS,
AIS NO. 178628,**

Plaintiff,

v.

**DR. DARBOUZE, NURSE KAY WILSON,
AND WARDEN DAVENPORT,**

Defendants.

**CIVIL ACTION NO.
2:07-cv-00630-MEF-WC**

**EVIDENTIARY SUBMISSION IN SUPPORT OF DEFENDANTS' RESPONSE TO
MOTION FOR PRELIMINARY INJUNCTION**

COME NOW, Defendants DR. JEAN DARBOUZE ("Dr. Darbouze") and NURSE KAY WILSON ("Nurse Wilson"), and submit the following evidentiary materials in support of their Response to Motion for Preliminary Injunction:

- A. Affidavit of Dr. Jean Darbouze;
- B. Affidavit of Kay Wilson, RN, H.S.A.; and
- C. Affidavit of Beth H. Long with a true and correct copy of pertinent excerpts from Plaintiff's medical records bates labeled PHS001 – PHS133.

Respectfully submitted this 22nd day of August, 2007.

s/ William R. Lunsford

One of the Attorneys for Dr. Jean Darbouze and Kay Wilson, RN

OF COUNSEL:

William R. Lunsford
Maynard, Cooper & Gale, P.C.
655 Gallatin Street
Huntsville, Alabama 35801
Telephone: (256) 551-0171
Facsimile: (256) 512-0119
Email: blunsford@maynardcooper.com

CERTIFICATE OF SERVICE

I hereby certify that on the 22nd day of August, 2007, I electronically filed the foregoing with the Clerk of the Court and mailed via regular U.S. mail or via electronic mail (as designated below) to the following:

Barry Randall Thomas
AIS # 178628
Easterling Correctional Facility
200 Wallace Drive
Clio, AL 36017-2613

Tara S. Knee (*via electronic mail*)
Alabama Department of Corrections
Post Office Box 301501
Montgomery, AL 36130-1501

s/ William R. Lunsford

Of Counsel

Exhibit “A”

Affidavit of Dr. Jean Darbouze

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
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BARRY RANDALL THOMAS,
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Plaintiff,

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DR. DARBOUZE, NURSE WILSON,
AND WARDEN DAVENPORT,

Defendants.

CIVIL ACTION NO.
2:07-cv-00630-MEF-WC

AFFIDAVIT OF DR. JEAN DARBOUZE

STATE OF ALABAMA)

COUNTY OF BARBOUR)

Before me, the undersigned Notary Public, personally appeared DR. JEAN DARBOUZE who, after being duly sworn, states as follows:

1. My name is Dr. Jean Darbouze. I am over the age of nineteen (19) years and have personal knowledge of the information contained in this affidavit.

2. I have been a licensed physician in Alabama since 1996 and have been board certified in internal medicine since 1997. From February of 2000 through February of 2004, and again from April 16, 2004 through the present, I have served as the Medical Director for Easterling Correctional Facility ("Easterling") in Clio, Alabama. Since November 3, 2003, I have been employed by Prison Health Services, Inc. ("PHS") as the Medical Director at Easterling.

3. I am familiar with Barry Randall Thomas ("Thomas"), an inmate who has been incarcerated at Easterling and who filed this lawsuit. It is my understanding that a true and

correct copy of his medical records are being submitted to the Court concurrently with this Affidavit and my statements below include specific citations to the Bates-labels affixed to the pertinent portions of Mr. Thomas's medical records.

4. Mr. Thomas's complaint of back pain originated in 1995. Mr. Thomas submitted a sick call request form dated January 18, 1995, writing, "pain in lower back for past three days." (PHS051). Mr. Thomas was evaluated the following day by the medical staff and was provided with pain medication and muscle relaxers. (PHS052). The medical staff at Bullock Correctional Facility specifically noted that upon examining Mr. Thomas on January 19, 1995, Mr. Thomas likely pulled a muscle in his back. (PHS052). After this January 19, 1995, episode of back pain, Mr. Thomas's complaints stopped.

5. Mr. Thomas submitted sick call request forms or other similar forms for non-urgent medical attention on July 18, 1996, July 24, 1996, July 25, 1996, August 8, 1996, January 1, 1997, November 2, 1997, January 6, 1998, August 5, 1998, November 29, 1998, January 31, 2001, July 15, 2002, October 14, 2002, October 19, 2002, April 6, 2003, and April 9, 2003. (PHS028, 30, 32, 33, 35, 36, 40, 42, 43, 45, 46, 47, 48, 50, 84-88). In a sick call request form dated April 3, 2004, Mr. Thomas complained of abdominal pain, but did not mention any pain with regard to his lower back. (PHS028). When examined by the medical staff on April 8, 2004, Mr. Thomas did not voice any complaints regarding lower back pain. (PHS014). In a sick call request form dated April 3, 2005, Mr. Thomas did not mention any complaints about lower back pain, but only complained of "constipation." (PHS027). When I examined Mr. Thomas on April 6, 2005, Mr. Thomas did not voice any complaints regarding lower back pain. (PHS013). In fact, Mr. Thomas did not mention any complaints of back pain for over ten (10) years, i.e. between January 19, 1995, and November 12, 2005.

6. Mr. Thomas completed a sick call request form dated November 13, 2005, complaining of lower back and left hip pain. (PHS025). After submitting his November 13, 2005, sick call request form, Mr. Thomas was evaluated by the medical staff. (PHS026). Mr. Thomas was examined by the medical staff during sick call and it was noted that he did not have any physical injuries or obvious signs of trauma to his lower back. (PHS026). Mr. Thomas was referred to me for further evaluation and given a prescription for Tylenol. (PHS026).

7. I examined Mr. Thomas on November 18, 2005. (PHS013). During this examination, Mr. Thomas complained of lower back pain, but denied any weakness, any prior surgeries and/or prior trauma which would in any way cause the complained of back pain. (PHS013). Upon examining Mr. Thomas, I only discovered mild muscular tenderness in Mr. Thomas's lower back and did not note any symptoms or problems which would indicate any type of neurological or other structural defect. (PHS013). After examining Mr. Thomas, I ordered that he undergo an x-ray of his lower spine, receive 10 mg of Flexeril three times a day for one week, Tylenol three times a day or as needed for two weeks and Feldene once a day in the evening for fourteen days. (PHS005, PHS013, PHS058). Feldene is a non-steroidal anti-inflammatory medication often utilized to reduce pain, swelling and/or stiffness associated with muscular strains, pain and discomfort. In a physician's order dated November 18, 2005, Mr. Thomas was also instructed to avoid prolonged standing. (PHS005, PHS111).

8. Mr. Thomas underwent an x-ray of his lumbar spine on November 21, 2005. The results of the November 21, 2005, x-ray demonstrated that, "[t]he vertebrae are well aligned and show no evidence of any fracture or any destructive bone disease." (PHS083).

9. I examined Mr. Thomas again on December 9, 2005. (PHS009). I noted that his lower back pain had not greatly improved and, in fact, worsened after prolonged periods of time

standing. (PHS009). Mr. Thomas requested during the December 9, 2005, appointment that I provide him with a profile allowing him to sit when necessary and directing the correctional staff to allow him to avoid prolonged periods of standing. (PHS009). In response to this request, I provided the requested prolonged standing profile as well as medication (Percogesic, Motrin) and topical cream (Bengay) intended to alleviate his muscular discomfort. (PHS009, PHS056-57, PHS110). After this November, 2005, episode of back pain, there were no further complaints of back pain from Mr. Thomas until May of 2007, just over three months ago.

10. In a sick call request form dated May 2, 2007, Mr. Thomas noted that his lower back pain continued but requested information as to whether there was a "different treatment" or whether the medical staff could "schedule a more sensitive exam – CT or MRI?" (PHS024). Mr. Thomas was summoned to the health care unit on May 3, 2007, for sick call, but he failed to appear. (PHS101). When Mr. Thomas underwent his yearly examination on May 11, 2007, the medical staff did note that Mr. Thomas complained of episodes of "sciatica." (PHS126).

11. Mr. Thomas completed a sick call request form dated May 13, 2007, in which he complained of "lower back and left leg pain." (PHS022). When Mr. Thomas reported his sick call on May 13, 2007, Mr. Thomas stated "my sciatic nerve is bothering me" and informed medical staff that it had been causing pain for approximately "2 months." (PHS023). Medical staff examined Mr. Thomas during the May 13, 2007, sick call and noted that Mr. Thomas walked evenly with a steady gait and complained only of dull, or aching pain to his left lower back. (PHS023). At the conclusion of the May 13, 2007, sick call, Mr. Thomas received 600 mg of Motrin and was referred to me for further evaluation. (PHS023, PHS055).

12. I examined Mr. Thomas again on May 15, 2006, during which Mr. Thomas voiced complaints of lower back pain. (PHS012). During the May 15, 2006, examination, Mr.

Thomas did not exhibit any symptoms of any particular spinal condition or disease, only complaining and demonstrating muscle tenderness in the left side of his left back. (PHS012). At the conclusion of the May 15, 2006, examination, I prescribed Motrin and Flexeril three times a day for Mr. Thomas and also directed Mr. Thomas to utilize only a bottom bunk. (PHS012, PHS055). Mr. Thomas received a bottom bunk profile from May 15, 2007, through May 30, 2007. (PHS100).

13. Mr. Thomas complained of continuing back pain in a sick call request form dated May 28, 2007. (PHS021). He submitted a second sick call request form dated May 30, 2007, in which he complained of continuing back pain and stated that his existing medications, including "pain medications and muscle relaxers," were not "alleviating symptoms." (PHS019).

14. On May 28, 2007, Mr. Thomas complained that he was unable to put any pressure on his left leg and was immediately brought to the healthcare unit for evaluation. (PHS099). After being examined by the medical staff at approximately 8:45 a.m. on May 28, 2007, Mr. Thomas was moved to the infirmary for observation by the medical staff. (PHS099). The medical staff noted that after Mr. Thomas was admitted to the infirmary on the morning of May 28, 2007, he was able to walk around the infirmary with assistance. (PHS099). By 12:10 p.m. on May 28, 2007, Mr. Thomas stated that he felt "better" and that "the pain comes and goes." (PHS099). Mr. Thomas was released from the infirmary at approximately 12:10 p.m. on May 28, 2007, and was encouraged to remain compliant with his medications. (PHS099).

15. Mr. Thomas was evaluated by the medical staff on May 30, 2007, in which he also complained of lower back pain. (PHS020). During the sick call on May 30, 2007, Mr. Thomas complained that his back pain had only existed for "3 months." (PHS020). At the conclusion of sick call, Mr. Thomas refused additional medication and was referred to me.

(PHS020). I provided Mr. Thomas with a bottom bunk profile, instructing him only to utilize a bottom bunk, beginning on May 30, 2007. (PHS004)

16. I examined Mr. Thomas on June 5, 2007, and this examination only revealed continuing muscular tenderness in Mr. Thomas's lower back pain. (PHS012). I continued Mr. Thomas's prescriptions for Motrin, Flexeril and Bengay as well as Mr. Thomas's order to utilize only a bottom bunk. (PHS004, PHS012, PHS096, PHS053).

17. When I examined Mr. Thomas on June 8, 2007, Mr. Thomas complained of continuing back pain, but did not demonstrate any tenderness in any bony section of his spine, only complaining of tenderness in the muscular section of his lower back. (PHS011, PHS095). At the conclusion of the June 8, 2007, examination, I concluded that there was no specific cause of Mr. Thomas's continued back pain other than muscular tenderness. (PHS011, PHS095).

18. Mr. Thomas received orders to undergo an x-ray of his lower spine as well as crutches on June 8, 2007. (PHS004). Mr. Thomas underwent an x-ray of his lumbar spine on June 12, 2007. (PHS082). The board-certified radiologist who reviewed the x-ray results of Mr. Thomas's June 12, 2007, study, concluded as follows, "[t]he vertebrae are well aligned and show no evidence of any fracture or other destructive bone disease." (PHS082).

19. On June 13 and 17, 2007, Mr. Thomas submitted a sick call request forms in which he complained of continued back pack. (PHS016, PHS018). Mr. Thomas failed to report to sick call on June 14, 2007, when he was summoned to the healthcare unit for examination. (PHS092). When presented with the "release of responsibility" form, Mr. Thomas refused to sign the document acknowledging his refusal to attend sick call. (PHS092).

20. Mr. Thomas acknowledged receipt of crutches from the medical staff at Easterling on June 15, 2007. (PHS093).

21. Mr. Thomas was evaluated by the medical staff on June 20, 2007. (PHS017). The medical staff noted that during the June 20, 2007, sick call, Mr. Thomas walked through the health care unit without any assistance, was able to stand and walk with a slow, steady gait and demonstrated some reduced range of motion. (PHS017). However, during the June 20, 2007, sick call, Mr. Thomas's focus primarily on his request for certain exceptions to existing facility protocols which are known as "profiles." (PHS017). On June 20, 2007, Mr. Thomas was referred to me for further evaluation. (PHS017).

22. Mr. Thomas was examined by a member of the medical staff on June 22, 2007, and admitted that he had refused an appointment with me. (PHS015, PHS091). On June 25, 2007, Mr. Thomas was moved to the infirmary at my direction for observation and to ensure that he received any assistance necessary from the medical staff at Easterling. (PHS004). Though Mr. Thomas complained of continued lower back pain and left leg pain during a June 25, 2007, examination, the examination by a member of the medical staff did not reveal any specific causes of his lower back pain. (PHS015). Mr. Thomas later received a prescription for 400 mg of Motrin two times a day on June 26, 2007. (PHS004).

23. When examined by the medical staff on June 26, 2007, Mr. Thomas complained of continuing lower back pain and, when asked when his back pain began, he stated that he "just woke up one day with back pain." (PHS011). At the conclusion of the June 26, 2007, examination, Mr. Thomas was instructed to continue his medication regiment as ordered by me. (PHS011, PHS053).

24. On June 28, 2007, I examined Mr. Thomas and noted that Mr. Thomas was utilizing a crutch and favoring his left side. (PHS010). During the June 28, 2007, examination, Mr. Thomas was able to bend over and touch his toes though he persistently protected his left

side. (PHS010). His medical records clearly recite that during the June 28, 2007, examination, Mr. Thomas complained of lower back pain, but did not show any tenderness in his sciatic notch or any type of muscle spasms which would indicate any specific cause for his back pain. At the conclusion of the June 28, 2007, examination, I noted that there was no objective way to determine if the pain complained of by Mr. Thomas was "really that intense or a true problem/complaint." (PHS010). Following the June 28, 2007, examination, we made minor changes to Mr. Thomas's medication regimens. (PHS010).

25. After evaluating Mr. Thomas on June 28, 2007, I discontinued Mr. Thomas's prescription for Motrin and Flexeril and ordered Mr. Thomas to take Naprosyn and Robaxin. (PHS003). All of these medications are commonly prescribed for individuals with recurrent or significant muscular discomfort or pain. Naprosyn, also known as Naproxen, is a form of ibuprofen which is commonly used for muscular pain. Robaxin, like Flexeril is a muscle relaxer, which is commonly prescribed for those individuals who suffer from any sort of chronic muscular pain. I also ordered Mr. Thomas to be housed in the infirmary for a period of approximately four days, be allowed to utilize crutches for approximately a week and remain in bed to the extent possible except for the occasions when he needed to leave his bed for medication administration and meals. (PHS003).

26. I entered orders for Mr. Thomas to receive Tylenol immediately in addition to his other medications on June 30, 2007 and July 1, 2007. (PHS003, PHS054).

27. I examined Mr. Thomas on July 2, 2007 noting some tenderness Mr. Thomas's lower spine, but also noting that the x-ray of Mr. Thomas's lower spine was negative. (PHS008). During this examination, I provided him with a prescription for crutches for one week, Tylenol three times a day for two weeks and the muscle relaxer, Flexeril, three times a day for two

weeks. (PHS002). I also ordered Mr. Thomas to undergo another x-ray of his lower spine as well as his left and right hips, which also failed to reveal any abnormalities, trauma or other injury or complications with regard to Mr. Thomas's lower back. (PHS002-PHS003). Mr. Thomas signed a "receipt of medical equipment/appliance form" on July 2, 2007, acknowledging his receipt of crutches. (PHS089 and 90).

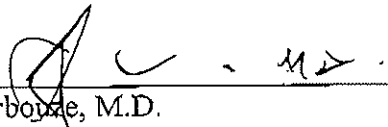
28. An x-ray was taken of Mr. Thomas's lumbar spine on July 2, 2007. (PHS073). Though the July 2, 2007, x-ray revealed "slight scoliosis" of Mr. Thomas's spine, the radiologist reviewing the x-ray results determined that there was no "disk space narrowing" or "evidence of recent fracture or other significant bony abnormality." (PHS073). Based upon the findings of this x-ray, it remains possible that Mr. Thomas eschewed the results of this x-ray by bending in a particular direction or not have appropriate posture during the x-ray.

29. Based upon the numerous examinations of Mr. Thomas, the various diagnostic and imaging testing completed regarding his complaints of back pain, I remain confident that his back pain is muscular in origin. My examinations of Mr. Thomas have not revealed any skeletal or neurological problems which would indicate that his back pain is caused by a malformation or disease of his spine. At present, the only objective medical findings available to us constitute Mr. Thomas's x-ray results. These x-ray results have been persistently normal, though the most recent results indicate some "slight" scoliosis which would not result in the type of pain described by Mr. Thomas. In the field of medicine, there is no objective way to test a patient to confirm that he or she is experiencing pain. In certain instances, extreme pain can be confirmed through tests such as blood pressure tests, but the evaluations of Mr. Thomas have not shown an fluctuation of his vital signs which would indicate that he is in any degree of traumatic or significant pain to such a degree. Ultimately, a physician is required to rely upon a patient in

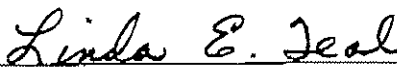
many instances to accurately describe pain and discomfort and is without any ability to confirm a patient's subjective descriptions of pain.

30. In the case of Mr. Thomas, I do not believe that there are any additional diagnostic or imaging tests which would be beneficial to Mr. Thomas at this time. Likewise, I am not aware of any additional medical treatment of any kind that may be provided by any other physician or specialist which would remedy Mr. Thomas's discomfort. My examinations of him have confirmed my conclusion that his pain is primarily, if not entirely, muscular in nature. I have not denied Mr. Thomas any necessary medical treatment or ignored his complaints to me. I have examined Mr. Thomas on a regular basis and will continue to do so in the future. I have attempted to control his pain through medication and will continue to do so in the future. I am vigilantly attempting to monitor any changes in his condition and, if such changes occur, we will respond in a timely fashion and provide all necessary medical attention and care. Thomas's condition at this time appears to be an instance when future care will depend, in large part, upon the manner in which his condition changes or improves. Given the history of his back pain, it remains possible that his condition will be remedied over time.

Further affiant saith not.


Jean Darbonne, M.D.

SWORN TO and SUBSCRIBED before this the 22nd day of August, 2007.


Linda E. Jeal

Notary Public

My Commission Expires: 7-11-11

(SEAL)

Exhibit “B”

Affidavit of Kay Wilson, RN, H.S.A.

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
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Plaintiff,

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**DR. DARBOUZE, NURSE WILSON,
AND WARDEN DAVENPORT,**

Defendants.

**CIVIL ACTION NO.
2:07-cv-00630-MEF-WC**

AFFIDAVIT OF KAY WILSON, R.N., H.S.A.

STATE OF ALABAMA

COUNTY OF BARBOUR

Before me, the undersigned Notary Public, personally appeared KAY WILSON, R.N., H.S.A., who, after being duly sworn, states as follows:

1. My name is Nurse Kay Wilson. I am over the age of nineteen (19) years and have personal knowledge of the information contained in this affidavit.

2. I have been a licensed, registered nurse in Alabama since 1985. I hold a Bachelor's Degree in nursing from Troy State University. Since 1985, I have practiced nursing in a variety of positions and settings. In particular, I have worked as a nurse at Easterling Correctional Facility in Clio, Alabama, since March of 2001. Since November 3, 2003, I have been employed as the Health Services Administrator (H.S.A.) for Easterling Correctional Facility ("Easterling") by Prison Health Services, Inc., the company which is currently under contract with the Alabama Department of Corrections to provide medical services to inmates in Alabama.

3. I am familiar with Barry Randall Thomas ("Thomas") who has been incarcerated at Easterling.

4. As a registered nurse at Easterling, I am not authorized to provide or order prescription medication for any inmate unless authorized to do so by a physician. Likewise, I am not authorized to diagnose any medical condition suffered by Mr. Thomas and, in particular, I am not authorized or qualified to consider his complaints of back pain or identify the cause of his complaints of back pain. Such decisions or conclusions must be made by his attending physician. I have not at any time attempted to diagnose the cause of Mr. Thomas's complaints of back pain.

5. When an inmate has a non-emergency medical or health problem and/or complaint, an inmate may file a sick call request form in order to bring this problem or complaint to the attention of the medical staff at Easterling and/or request medical treatment for this problem. The sick call request process is well-known at Easterling and is utilized by inmates at Easterling on a daily basis. When an inmate first arrives at Easterling, he is taken to the Health Care Unit to be processed into the system and receives an orientation as to the availability of medical services at the facility as well as the procedures for obtaining medical care. During this orientation, the medical staff gives each inmate an information sheet and verbally goes through the sheet with newly-arriving inmates, informing them how to utilize the sick call request form process. Sick call request forms are available in the Health Care Unit at the shift commander's station or may be obtained from the Alabama Department of Corrections ("ADOC") officer in each dorm at Easterling. An inmate making a sick call request is required to complete the top portion of the sick call request form (stating his name, the date of request, AIS number, date of birth, dorm location, the nature of the problem or request and his signature) and submit the sick

call request form by placing it in a locked box located outside the facility's kitchen (i.e., chow hall). The sick call request forms are removed from the locked box each day and brought to the Health Care Unit. Upon retrieving the sick call request forms, the medical staff compiles a list of inmates having submitted a sick call request form, which is sent to the various dorms at Easterling. Easterling conducts sick call five (5) times per week, Sunday through Friday excluding holidays or unexpected emergencies. Sick call begins at 7:00 p.m. and lasts as long as required to examine all the inmates who report to sick call. Inmates who submit sick call request forms are responsible for reporting to the Health Care Unit for evaluation of their complaints at the time they are summoned to the Health Care Unit for sick call. The number of inmates reporting to sick call each day varies between approximately ten (10) and thirty-five (35). The nurse conducting sick call takes reporting inmates' vital signs and either: (1) provides an inmate with medical treatment that can be provided under the nursing protocols, or (2) refers the inmate to the physician or nurse practitioner on staff at Easterling. If the inmate fails to report to sick call when summoned, this is often indicated in the sick call request form because it is left blank by the medical staff. If the medical complaints or problems identified by an inmate in a sick call request form appear to be urgent or life-threatening, the medical staff will immediately have the inmate brought to the infirmary (located within the Health Care Unit) and the inmate will be examined and treated by a physician.

6. My involvement with the complaints made by Mr. Thomas and the attempts by the medical staff at Easterling to identify the cause of his complaints of back pain have been limited to providing responses to one grievance form completed by Mr. Thomas and received by me in June of 2007. In the grievance form completed by Mr. Thomas, he complained of back pain and requested a wheelchair and an appointment with a specialist. Mr. Thomas also

requested "profiles," which are orders provided by the site physician which allow an inmate to deviate from the standard operating procedures at Easterling. In particular, Mr. Thomas requested a profile from the site physician which ordered him to avoid standing or working and allowed him to use the handicap-accessible shower facility at Easterling. As an RN, I am not authorized to determine whether Mr. Thomas's medical complaints justified the issuance of the profiles he requested. When I received Mr. Thomas's first grievance, I promptly reviewed his file and noted that he had been evaluated by Dr. Darbouze within the last week and that Mr. Thomas had received crutches and a bottom bunk profile from Dr. Darbouze during his last appointment. I also confirmed that Mr. Thomas had recently submitted a sick call request form and was scheduled for evaluation during the upcoming sick call. Given my review of his medical records and the notes from his recent appointment with Dr. Darbouze, it did not appear to me that Mr. Thomas's back pain was a medical emergency at that time or that there was anything additional that I could contribute to the treatment of his back pain, which was not being provided and/or would be provided at the upcoming sick call.

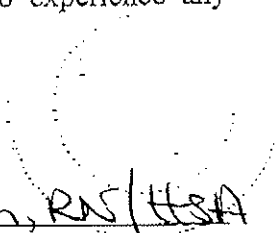
7. Approximately 10 days after I received Plaintiff's grievance, the medical staff received a grievance appeal from Mr. Thomas, in which he continued to complain of back pain. I neither received nor reviewed this grievance and was not involved in evaluating the complaints made by Mr. Thomas in this grievance appeal. Another member of the medical staff at Easterling evaluated this grievance appeal, reviewed his medical records and provided a response.

8. I have not been responsible for conducting any examination or interview of Mr. Thomas on the occasions he has attended sick call or otherwise appeared in the health care unit

at Easterling seeking medical treatment. Those tasks were assigned to other members of the medical staff at Easterling.

9. Based upon my understanding of Mr. Thomas's complaints of back pain (both past and present) and the examinations and treatment he has received as of this date, it is evident that Mr. Thomas has received timely and appropriate medical care. I have not at any time ignored any request by Mr. Thomas for medical treatment. I have not deliberately ignored Mr. Thomas's medical complaints or refused to provide Mr. Thomas with any necessary medical treatment. I have not taken any action which has caused Mr. Thomas to experience any unnecessary pain and/or suffering.

Further affiant saith not.


Kay Wilson, RN/HSA
Kay Wilson, R.N., H.S.A.

SWORN TO and SUBSCRIBED before this the 22nd day of August, 2007.

Linda E. Deal
Notary Public
My Commission Expires: 7-11-11

(SEAL)

Exhibit “C”

Affidavit of Beth H. Long with a true and correct copy of
pertinent excerpts from Plaintiff’s medical records bates
labeled PHS001 – PHS133

AFFIDAVIT

STATE OF ALABAMA)

Barbour COUNTY)

I, Beth H Long, hereby certify and affirm that I am a Medical Records Clerk, at Easterling Correctional Facility; that I am one of the custodians of medical records at this institution; that the attached documents are true, exact, and correct photocopies of certain medical records maintained here in the institution medical file of one Barry Randall Thomas, AIS# 178628; and that I am over the age of twenty-one years and am competent to testify to the aforesaid documents and matters stated therein.

I further certify and affirm that said documents are maintained in the usual and ordinary course of business at Prison Health Service - ECF; and that said documents (and the entries therein) were made at, or reasonably near, the time that by, or from information transmitted by, a person with knowledge of such acts, events, and transactions referred to therein are said to have occurred.

This, I do hereby certify and affirm to on this the 27th day of July, 2007

Beth H Long

SWORN TO AND SUBSCRIBED BEFORE ME THIS THE

27th Day of July, 2007

Linda E. Seal

Notary Public

7-11-11

My Commission Expires



PHYSICIANS' ORDERS

NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Last Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Thomas Barry	DIAGNOSIS (If Chg'd)
D.O.B. 1/20/66	Discontinue previous order for the 1 week
ALLERGIES: NKA	Discontinue Roxitrol
Use Fourth Date 7/5/07	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Thomas Barry	DIAGNOSIS (If Chg'd) LBP
D.O.B. 11/20/66	Naproxen 375mg to BID x 2 weeks
ALLERGIES: NKA	Discontinue to Roxitrol
Use Third Date 7/2/07	for 1 week
	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Thomas Barry	DIAGNOSIS (If Chg'd) LBP
D.O.B. 11/20/66	PSA, DR III
ALLERGIES: NKA	Cantolox X 1 week
Use Second Date 7/2/07	Tylenol 1g to TID x 2 weeks
	Floxacin 100mg to TID x 2 weeks
	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Thomas Barry	DIAGNOSIS LBP
# 178628	X Ray of L-S spine
D.O.B. 11/20/66	X Ray of R and L hip
ALLERGIES: NKA	
Use First Date 7/2/07	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED

MEDICAL RECORDS COPY

PHS002



PHYSICIANS' ORDERS

NAME: Thomas Barry 178628 D.O.B. 11/20/66 ALLERGIES: NKA Use Last Date 7/11/07	DIAGNOSIS (If Chg'd) Tylenol 1g po. now: 2 bid x 240 v10 Dr. Darboush/L. Ewing <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Thomas Barry 178628 D.O.B. 11/20/66 ALLERGIES: NKA Use Fourth Date 6/30/07	DIAGNOSIS (If Chg'd) Tylenol 1gm po X 1 dose now <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Thomas Barry 178628 D.O.B. 11/20/66 ALLERGIES: NKA Use Third Date 6/28/07	DIAGNOSIS (If Chg'd) (8) LAG in X 3 days 1/2 cup for mess, chow. <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Thomas Barry 178628 D.O.B. 11/20/66 ALLERGIES: NKA Use Second Date 6/28/07	DIAGNOSIS (If Chg'd) (5) In house U.A (6) Cont in infirmary until Monday. (7) 1 pin of Outech X 7 days - show proper usage <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Thomas Barry 178628 D.O.B. 11/20/66 ALLERGIES: NKA Use First Date 6/28/07	DIAGNOSIS (1) D/L Motrin (2) NA pro syn 325 TID X 30 days (3) D/L Flexeril (4) Robaxin 500mg BID X 10 days <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

PHS003



PHYSICIANS' ORDERS

NAME: Thomas Barry 178628 D.O.B. 11/20/66 ALLERGIES: NKA Use Last Date 6/26/07	DIAGNOSIS (If Chg'd) Moln 400mg BID prn X 2 day Floyd / J <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Thomas Barry 178628 D.O.B. 11/20/66 ALLERGIES: NKA Use Fourth Date 6/25/07	DIAGNOSIS (If Chg'd) Place in infirmary for observation and assistance as needed & ADZ until seen by provider. Document on pt. Phone order Dr. McQueen / Colman <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Thomas Barry 178628 D.O.B. 11/20/66 ALLERGIES: NKA Use Third Date 6/18/07	DIAGNOSIS (If Chg'd) LBP / Myalgia Catch X i week X-ray of L-S spine Discharge to hospital <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Thomas Barry 178628 D.O.B. 11/20/66 ALLERGIES: NKA Use Second Date 6/15/07	DIAGNOSIS (If Chg'd) LBP BBP X 2 weeks Moln 600mg Po TID prn X 14 days Pleco 10mg Po TID prn X 14 days Bengay mit BID prn X 5 days <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Thomas Barry 178628 D.O.B. 11/20/66 ALLERGIES: NKA Use First Date 5/30/07	DIAGNOSIS Continue Bottom Bunk, prn until seen by MD on 6-5-07 w Dr. Dardane / Colman <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED



PHYSICIANS' ORDERS

NAME: Thomas Barry D.O.B. 11/20/66 ALLERGIES: NKDA Use Last Date 11/18/05	DIAGNOSIS (If Chg'd) 1/2 3 weeks No prolonged standing x 2 week <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Thomas Barry # 178628 D.O.B. 11/20/66 ALLERGIES: NKDA Use Fourth Date 11/18/05	DIAGNOSIS (If Chg'd) x-ray L-S spine Feldene 20mg Po QPM x 14 days PRN Tylenol 1g Po TID PRN x 14 days Flexeril 10mg Po TID PRN x 7 days <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Thomas Barry 178628 D.O.B. 11/20/66 ALLERGIES: NKDA Use Third Date 11/16/05	DIAGNOSIS (If Chg'd) Constipation MOM 2000 Po x 1 Dulcolax 10 Po x 1 Dulcolax 100mg Po QD x 14 days <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Thomas Barry 178628 D.O.B. 11/20/66 ALLERGIES: NKDA Use Second Date 11/23/04	DIAGNOSIS (If Chg'd) DC chronic case Lab work - Diag. Profile II - 048827 <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: Thomas Barry # 178628 D.O.B. 11/20/66 ALLERGIES: NKDA Use First Date 8/18/04	DIAGNOSIS DC loped DC chronic case Lab work - Diag. Profile II - 048827 <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED



PHYSICIANS' ORDERS

NAME: <u>Thomas, Barry</u> <u># 178628</u> D.O.B. <u>11/20/66</u> ALLERGIES: <u>NKA</u> Use Last Date <u>8/18/04</u>	DIAGNOSIS (If Chg'd) <u>Lipid 600mg. i po BID</u> <u>x 1 year</u> <u>no Dr. Darkhouse / Kewelson RN</u> <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Fourth Date / /	DIAGNOSIS (If Chg'd) <u>Lipid 600mg. i po BID x</u> <u>90 days</u> <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: <u>Thomas - Barry</u> D.O.B. <u>11/20/66</u> ALLERGIES: <u>NKA</u> Use Third Date <u>6/26/2007</u>	DIAGNOSIS (If Chg'd) <u>Lipid 600mg i po BID x 90 days</u> <u>DK Darkhouse / Kewelson RN</u> <u>Start 6-26-2007 - 9-24-2007</u> <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: <u>Thomas, Barry</u> <u>178628</u> D.O.B. <u>11/20/66</u> ALLERGIES: <u>NKA</u> Use Second Date <u>4/15/04</u>	DIAGNOSIS (If Chg'd) <u>Lipid 600mg i po BID x 90d KOP</u> <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: <u>Thomas Barry</u> <u>178628</u> D.O.B. <u>11/20/66</u> ALLERGIES: <u>NKA</u> Use First Date <u>4/8/04</u>	DIAGNOSIS <u>Went solution to Trunk BID</u> <u>x 6 weeks</u> <u>Drug Abuse II 09/8827, seal rate</u> <u>Stool x 3 hereafter flag on chart</u> <u>metamucil 3.4 gm in 10 oz liquid po QD</u> <u>KOP x 3 mos</u> <input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED

MEDICAL RECORDS COPY

NC002

NC002

NC002

PHS007



PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
7/2/07	Thomas, Barry	11/20/66
8/25	WT 153 BP 134/86 P III R L8 T 97	
	Intimacy	02 sat 9/10
	40 mm of pain to 2 lower back → L leg X	
	few years, worse over the past few months, 2-3 times a day / trauma	
	0. note, x-ray	
	L spine: on index over the L-S vertebrae. fine tenderness over the L pars interarticularis. ROM limited by up back / stiffness straight leg raising: -1. Numbness: intact.	
	X-ray L spine 8/8/07: negative.	
11/2	last likely 20 to spine. This is better by. - report X-ray - ROM 20-25° - 1 week	
1/5/07	X-ray of L spine: neg. R/L better. 20° - continue for appt. Rtc Real	



PRISON
HEALTH
SERVICES
INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
12-9-05	Thomas Barry	11/120/66
176 #	974 P106 16	11/8/78
2	<p>By lower back pain. % not getting my relief from the power, Meds. - % L&P → in leg - fragment for the physical therapy w/ file</p>	
1-10-06	<p>NOTE: v12 L spine in touch not good - with % pain Nurse: what X-ray: NAT</p>	
4/1/06	<p>L dr for: Acupuncture, when TID read Barry B1 > read etc read</p>	

Date/Time

Inmate's Name:

D.O.B.:

/ /

6/28/07

Worked as a printer mostly.

① walk c crutch favor (L) side
lean to R side.

st. leg (R) on (L).

φ Sciatric notch tenderness

- flex is both lower to chest but is not strong like but (L) leg
(bow sign +)

- L-S spine TTP L4-5

- bend over to touch toes protruding
(L) side.

- φ para vertebral muscle span to
this disorder.

(A) Low Back pain c (L) leg pain? Also
Lumbar spine wnl

(P) Pt pretty consistent to finding on (L) but
can't tell if it is really that intense
or a true problem/complication

(C) POC - c minor change in mass. *[Signature]*



PRISON
HEALTH
SERVICES
INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
6/8/07 7 ^{PM}	Thomas Barry	11/20/66
6/8/07 7 ^{PM}	INP/BC	
	WT 160 B/p 128/80 p 105 R18 T98° O ₂ 96%	
	cl. pain to the L lower back - no radiating with no associated weakness/numbness/loss of sensation states not to be able to walk early in Aug	
0.	NAR. V82	
	L spine = + tenderness & paraspinal muscle, more ↓ 2" L than. no tenderness over the L vertebrae.	
	Mr. Barry also focal defect	
6/8/07 1 ^{PM}	LBP	
	Mr. Barry continue treatment p. 1 Continue to walk early in Aug x 2 weeks then operation - not sure	
6/26/07 8 ^{AM}	WT 153 B/p 140/70 p 100 R20 T98° O ₂ 93%	
	⑤ 40 y w o o c/o Back & L leg pain since 1995 - at least once a year. It last ran 4-5 months. No h/o injury. Just woke up 1 day to back pain. Suddenly last year, the pain started down L leg.	
	Accos day pain. Painful defecation, largely to amazing heart as well	

Date/Time Inmate's Name: Thomas Bawry D.O.B.: 11/12/1966
 5-15-06 182# 120/84 75 96# 16

SC

40 BM % Pain to his lower back x 1-2 week worse with
 rest, improved by exercise. No % injury/Trauma -
 Request for physical -
 0 - none, v.s.

L spine: + tenderness over the left paraspinal
 muscle - ROM ↓ with % pain

Neuro: intact

Xray: WAP (L spine).

7/2/07 Lost 20 to muscle spasm -

PL: Motion, + Flexion/ TID pain.

- Bony, Ray exposure -

- Bony, granted x 2 weeks

6/5/07 Wt 182 BP 126/82 P 95 R 18 T 978

835am S/C 49 BM % Pain to the left lower back - Pt is seeking
 a BAP

0 - none, v.s.

Long, v.s. Hantman

L spine: mild tenderness over the L4-L5 nerve over
 the paraspinal muscles - ROM no preferred because
 of % pain.

Neuro: intact

7/2/07

PL: Motion, Flexion, Bony, Ray
 for exposure

Bony, granted x 2 weeks

4-6-05 wt 184 B/P 122/74 R 20 P 78 T 97°
 750A Lower ABD Pain / Constipation
 S 2x rx w/ Constipation and lower abd pain - had a small
 bowel yesterday - denies N/V/diarrhea/chills - Hx, present w/ consti-
 pation
 O- N/A, x65
 Lung: clear Heart: normal
 Abd: w/ abd pain distended
 no tenderness / any organs negative
 Hx Constipation
 Rx: Motilium + Intalax in B x 1
 Colace w/ y to C/O Pass x 1 day
 ↑ water intake - return pass

11/18/05 wt 180 B/P 120/80 P-80 R 18 T 98
 S/C back / hip pain
 S 4x rx w/ Bx to hrs 2 hours back → L leg with
 associated numbness and tingling - He denies weakness,
 incontinence of B/P - Denies any Hx injury or Trauma
 The pain is with exertion or rest
 O- N/A, x65
 2 spine: mild tenderness - tender and painful
 Nerves: intact
 Hx L 4/5
 Rx: Tylenol + Feldene 2x
 Flexand 2x
 X-ray 2 spine w/ 2 weeks



PRISON
HEALTH
SERVICES
INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: <u>Marshall, William Thomas Bobby</u> D.O.B.: <u>11/20/1960</u>
<u>4/8/04 3:40 PM</u>	<p>wt. 180 120/80 64 16 T 97.8 SC <u>abd pain</u></p> <p>Has had this since 2002 RLO pain</p> <p>when it happens he gets ↓ appetite, radiates to LLQ</p> <p>no tests done. Says he felt like he had temp.</p> <p>PE Feels better now x 3 days</p> <p>PE Wt. MAD w/out @ Thru's</p> <p>lungs CTA</p> <p>heart RRR om</p> <p>Abd soft NT @ masses UA -ve</p> <p>A possible diverticulosis & episode of abd pain</p> <p>P Drug pub II stool hemoccult.</p> <p>Abd soft to w/out</p> <p>metformin QD</p> <p>FU if returns</p> <p><i>WV/Anderson</i></p>



PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
6-25-07 1600	Thomas Barry	11/20/1966
	<p>Spoke w/ pt regarding ongoing back problems. States she has had this condition on/off since 1994. Ambulated to HCU w/ the assistance of a mop for support. C/O hip pain radiating down leg. States unable to walk, use or perform ADL's assistance. States unable to bathe or dress himself w/ assistance. C/O numbness and tingling to R leg. Bilateral pedal pulses present. Capillary refill < 3 seconds. Able to move feet & toes. C/O pain upon movement of leg. Wt 155 lbs today. Pt had appt w/ DR. Danouze on 6-22-07. When questioned why he refused appointment he stated that the knee dr "Doctor was not going to do anything for me". Explained to pt that if a course of treatment does not work then he needs to follow up with the doctor so that he can re-evaluate for further treatment needs. Spoke w/ DR McGuire regarding pt and of above findings. Rec'd order to place pt in infirmary until seen by provider. The nurses are to document and assist pt as needed w/ ADL's. Pt placed in bed 2 in infirmary. Oriented to infirmary & care team system. Verbalizes under- Johnson </p>	

5/85)

Complete Both Sides Before Using Another Sheet



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: BARRY R. THOMAS Date of Request: 6-17-07
 ID # 178628 Date of Birth: 11/20/66 Location: E2-6A
 Nature of problem or request: sciatica for 3 months now. Acute, chronic pain. Meds not helping. No longer able to walk - using wheelchair borrowed from HCU since 1st Wednesday. Dr. Darbouze refuses to give even a no-prolonged-standing profile. Officers acknowledge need for wheelchair.
Barry Thomas
 Signature

DO NOT WRITE BELOW THIS LINE

Date: 6/20/07
 Time: 2:10 AM ☒ PM
 Allergies: _____

RECEIVED
Date: <u>6-20-07</u>
Time: <u>2:10</u>
Receiving Nurse Initials _____

(S)ubjective: See net tool dated 6/20/07 ~~renew~~
with

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

X Barry Thomas

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Facility: Alabama Department of Corrections

Patient Name: Thomas, Barry

Inmate Number: 178628 Last First MI

Date of Report: 6/20/07 MM DD YYYY

Date of Birth: 11/20/66 MM DD YYYY

Time Seen: 2:10 AM/PM Circle One

Subjective: Chief Complaint(s): "left sciatica for three months no. the meds not helping."

Onset: x 3 months

☒ New onset ☐ Chronic condition exacerbation

Pain Scale: (1-10) 10 Type: ☒ Sharp ☐ Dull ☐ Intermittent ☒ Constant

Location of Pain: ① down back Neck / mid back / low back

Radiation of pain: ☐ No ☒ Yes to: to ① leg

Numbness: ☐ No ☒ Yes ① foot

History:

(Continue on back if necessary)

☐ Check Here if additional notes on back

Associated symptoms: Pain on urination? ☐ No ☐ Yes Nausea ☐ No ☐ Yes Vomiting ☐ No ☒ Yes (x)

Increased urination? ☐ No ☐ Yes Pain with cough/breathing? ☐ No ☐ Yes

Objective: Vital Signs: (If Indicated) T: 98.1 P: 80 RR: 18 B/P: 124/78

Back Exam: ☐ Tender to touch ☐ Confusion ☐ Muscle spasms ☒ Impaired range of motion

Additional Findings: ☐ Numbness ☐ Tingling ☐ Abnormal gait ☐ Weakness of extremities ☐ Foot drop ☐ Other:

Elaborate positive findings:

Lower extremities: ☒ Normal ☐ Abnormal (Describe):

Pedal pulses: ☒ Present ☐ Absent

☐ Check Here if additional notes on back

☒ Additional Examination: W/M ambulates to HCU via W/C. Able to stand/walk c slow, steady gait. AOX3 Rep & ease. Skin warm & dry to touch. Regret profile

(Continue on back if necessary)

☐ Check Here if continued on back

Assessment: (Referral Status)

☐ Referral NOT Required

Preliminary Determination(s):

☒ Referral Required due to the following: (Check all that apply)

☐ Loss of sensation ☐ Presence of RBCs from dipstick ☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Prior malignancy ☐ Presence of WBCs from dipstick

☒ Other: to be evaluated by MD

Plan:

Check All That Apply: ☐ Work and recreation restrictions x 72 hours

☐ Education on avoiding back pain ☐ Education about stretching and back exercises. ☐ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☒ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other:

(Describe)

☐ Cold Compress (Acute injury) ☐ Warm Compress

☐ OTC Medications given (Motrin 400 or Tylenol 650 Bid pm x 2 days) * ☐ NO ☒ YES (If Yes List): Refused by pt

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Dr Darlow Date for referral: 6/25/07

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):

MM DD YYYY Time

x CWambleson Name: CWambleson

Nurses Signature

Printed



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: BARRY R. THOMAS Date of Request: 6/13/07
 ID # 178628 Date of Birth: 11/20/66 Location: E2-6A
 Nature of problem or request: continued pain from sciatica - lower back
and left leg. Meds not helping. Can no longer walk to pill call
and chow without borrowing wheel chair.

Barry R. Thomas
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

<p>RECEIVED</p> <p>Date: _____</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>

(S)ubjective:

*See waiver
6-14-07
7:30pm*

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: BARRY R. THOMAS Date of Request: May 30, 2007
 ID # 178628 Date of Birth: 11/20/66 Location: E2-6A
 Nature of problem or request: sciatica - lower back pain with pain radiating down
(L) leg. Pain medication & muscle relaxers not alleviating symptoms.
Request to see doctor again.

Barry R. Thomas
Signature

DO NOT WRITE BELOW THIS LINE

Date: 5/30/07
 Time: 540 AM ☒ PM
 Allergies: _____

RECEIVED	
Date:	<u>5/30/07</u>
Time:	
Receiving Nurse Initials	<u>ML</u>

(S)ubjective:

See Net tool dated 5-30-07

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: 110/70 WT: _____

(A)ssessment:

(P)lan:

X Barry Thomas

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Facility: Alabama Department of Corrections

Patient Name: Thomas, Barry

Inmate Number: 178628

Date of Report: 5/30/07

Date of Birth: 11/20/66

Time Seen: 540 AM PM Circle One

Subjective: Chief Complaint(s): "I have sciatica. Lower back pain with pain radiating down my left leg." Denies injury

Onset: X 3 months

Pain Scale: (1-10) 6 Type: ☒ Sharp ☒ Dull ☐ Intermittent ☐ Constant

Location of Pain: Back Radiation of pain: ☐ No ☒ Yes to: leg to heel

History: Request to see MD

Associated symptoms: Pain on urination? ☒ No ☐ Yes Nausea ☒ No ☐ Yes Vomiting ☒ No ☐ Yes (x)

Increased urination? ☒ No ☐ Yes Pain with cough/breathing? ☒ No ☐ Yes

Objective: Vital Signs: (If Indicated) T: 98.2 P: 68 RR: 18 B/P: 120/70

Back Exam: ☒ Tender to touch ☐ Contusion ☐ Muscle spasms ☒ Impaired range of motion

Additional Findings: ☐ Numbness ☐ Tingling ☐ Abnormal gait ☐ Weakness of extremities ☐ Foot drop ☐ Other:

Elaborate positive findings:

Lower extremities: ☒ Normal ☐ Abnormal (Describe):

Pedal pulses: ☒ Present ☐ Absent

Additional Examination: W/m ambulates c dow, steady gait. A to x 3 Reps

case. Skin warm & dry to touch.

Assessment: (Referral Status)

☐ Referral NOT Required

Preliminary Determination(s):

☒ Referral Required due to the following: (Check all that apply)

- ☐ Loss of sensation ☐ Presence of RBCs from dipstick ☐ Recurrent Complaint (More than 2 visits for the same complaint)
- ☐ Prior malignancy ☐ Presence of WBCs from dipstick
- ☐ Other:

Plan:

Check All That Apply: ☐ Work and recreation restrictions x 72 hours

☒ Education on avoiding back pain ☒ Education about stretching and back exercises. ☒ Instructions to return if condition worsens.

☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☒ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☒ Other: Continue BBP until seen by MD on 6-5-07 w/ Dr. Daulance / CW Ambler

☐ Cold Compress (Acute injury) ☐ Warm Compress

☐ OTC Medications given (Motrin 400 or Tylenol 650 Bid pm x 2 days): ☒ NO ☐ YES (If Yes List): PT refused

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Dr. Daulance

Date for referral: 6/5/07

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):

Time

x CW Ambler

Nurses Signature

Name:

Printed



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: BARRY R. THOMAS Date of Request: MAY 28, 2007
 ID # 178628 Date of Birth: 11/20/66 Location: E2-6A
 Nature of problem or request: Sciatica - lower-back pain radiating down left leg.

Barry R. Thomas
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

RECEIVED	
Date:	<u>5-29-07</u>
Time:	<u> </u>
Receiving Nurse Initials	<u> </u>

(S)ubjective:

See waiver dated 5-29-07 w/PA

(O)bjective **(V/S):** T: P: R: BP: WT:

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PHS021



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: BARRY R. THOMAS Date of Request: 5/13/07
 ID # 178628 Date of Birth: 11/20/66 Location: E2-666
 Nature of problem or request: Lower-back & left leg pain - pressure on sciatic nerve that has left me barely able to walk.

Barry R. Thomas
Signature

DO NOT WRITE BELOW THIS LINE

Date: 5/13/07
 Time: 715 AM ☒ PM
 Allergies: _____

RECEIVED Date: _____ Time: _____ Receiving Nurse Initials _____

(S)ubjective:

See net tole dated 5-13-07
CW/PAW

(O)bjective: (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections	
Patient Name: <u>Thomas, Barry</u>	
Inmate Number: <u>178628</u>	Date of Birth: <u>11</u> <u>20</u> <u>1966</u>
Date of Report: <u>5</u> <u>13</u> <u>07</u>	Time Seen: <u>7:15</u> AM/PM Circle One

Subjective: Chief Complaint(s): "My sciatic nerve is bothering me."

Onset: X 2 months

Brief History:

(Continue on back if necessary)

WT-174# SpO2 97% RA
Objective: Vital Signs: (As Indicated) T: 98.2 P: 64 RR: 16 B/P: 118 176

☐ Check Here if additional notes on back

Examination Findings:
 (Continue on back if necessary)

W/m ambulates even, steady gait. A+O x 3 Resp c
 case. SKIN warm + dry to touch. C/O dull, aching pain to (L) ↓ back
 radiating down (L) leg to (L) ankle. States 8/10 on pain scale. Denies
 injury. (L) tenderness to touch noted to (L) ↓ back. (L) ↓ ROM noted.
 Pedal pulse present + strong. NO acute distress noted.

☐ Check Here if additional notes on back

Assessment: (Referral Status)

Preliminary Determination(s):

☒ Referral NOT REQUIRED

☒ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☒ Other: to be evaluated by MD

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.

☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☒ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other:

(Describe)

OTC Medications given ☐ NO ☒ YES (If Yes List): Motrin 600mg po BID PRN x 5 days w/ Dr Darbouze

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Dr Darbouze

Date for referral: 5/14/07

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?):

Time

x

CWambles
 Nurses Signature

Name: CWambles RN
 Printed



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: BARRY R. THOMAS Date of Request: 5/02/07

ID # 178628 Date of Birth: 11/30/66 Location: E2-66b

Nature of problem or request: Continued acute & low-back pain radiating down @ leg, affecting my ability to walk normally. Insomnia & spasms due to pain. Previous treatment did not relieve symptoms. Could you try different treatment? Since X-ray exam revealed no abnormalities, could you schedule a more sensitive exam - CT or MRI? Continuous problem since 11/05.

Barry R. Thomas
Signature

DO NOT WRITE BELOW THIS LINE

Date: 5/3/07

Time: _____ AM PM

Allergies: _____

RECEIVED

Date: _____

Time: _____

Receiving Nurse Initials _____

(S)ubjective: Waiver

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

[Signature]
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: BARRY R. THOMAS Date of Request: 11/13/05
 ID # 178628 Date of Birth: 11/20/66 Location: 8B-131
 Nature of problem or request: lower-back and left hip pain — feels like
sciatic nerve is pinched

Barry R. Thomas
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

RECEIVED	
Date:	<u>11/14/05</u>
Time:	<u> </u>
Receiving Nurse Initials	<u>MP</u>

(S)ubjective:

(O)bjective **(V/S):** T: P: R: BP: WT:

(A)ssessment:

*See
Ref*

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

[Signature]

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Facility: <u>Thomas Be Easterling</u>	
Patient Name: <u>Thomas Barry</u>	
Inmate Number: <u>178628</u>	Date of Birth: <u>1</u> / <u>1</u> / <u>1</u>
Date of Report: <u>1</u> / <u>1</u> / <u>1</u>	Time Seen: <u>AM</u> / <u>PM</u> Circle One

Subjective: Chief Complaint(s): Back pain

Onset: 9 days

☐ New onset ☒ Chronic condition exacerbation

Pain Scale: (1-10) 7 Type: ☒ Sharp ☐ Dull ☐ Intermittent ☒ Constant Numbness: ☐ No ☒ Yes

Location of Pain: Lower left Radiation of pain: ☐ No ☒ Yes to: leg to foot

History: "My lower back is hurting radiating to my leg and foot causing numbness and tingling"
(Continue on back if necessary) ☐ Check Here if additional notes on back

Associated symptoms: Pain on urination? ☒ No ☐ Yes Nausea ☒ No ☐ Yes Vomiting ☒ No ☐ Yes (x)
Increased urination? ☒ No ☐ Yes Pain with cough/breathing? ☒ No ☐ Yes

Objective: Vital Signs: (If Indicated) T: 98 P: 68 RR: 16 B/P: 110 / 80

Back Exam: ☐ Tender to touch ☐ Contusion ☐ Muscle spasms ☐ Impaired range of motion

Additional Findings: ☒ Numbness ☒ Tingling ☐ Abnormal gait ☐ Weakness of extremities ☐ Foot drop ☐ Other: pt 90

Elaborate positive findings: _____

Lower extremities: ☒ Normal ☐ Abnormal (Describe): _____
Pedal pulses: ☒ Present ☐ Absent ☐ Check Here if additional notes on back

Additional Examination: \$ Visible injuries noted pt denies any injuries
(Continue on back if necessary) ☐ Check Here if continued on back

Assessment: (Referral Status)

☐ Referral NOT Required

Preliminary Determination(s): _____

☒ Referral Required due to the following: (Check all that apply)

☒ Loss of sensation pt 90 ☐ Presence of RBCs from dipstick ☒ Recurrent Complaint (More than 2 visits for the same complaint)
☐ Prior malignancy ☐ Presence of WBCs from dipstick
☐ Other: _____

Plan:

Check All That Apply: ☐ Work and recreation restrictions x 72 hours

☒ Education on avoiding back pain ☒ Education about stretching and back exercises ☐ Instructions to return if condition worsens.

☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: _____

(Describe)
☐ Cold Compress (Acute injury) ☐ Warm Compress

☐ OTC Medications given ☐ NO ☒ YES (If Yes List): Tylenol 1gm po bid x 5 days

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Dr Danks Date for referral: 11 / 18 / 05

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____ Time: _____

x Danks
Nurses Signature

Name: C Garcia
Printed



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: BARRY R. THOMAS Date of Request: April 3, 2005
 ID # 178628 Date of Birth: 11-20-66 Location: 8B-131
 Nature of problem or request: CONSTIPATION SINCE THURSDAY the 31st.

Barry R. Thomas
Signature

DO NOT WRITE BELOW THIS LINE

Date: 4.4.05
 Time: 8:20 AM PM (P)
 Allergies: NKDA

RECEIVED Date: <u>APR - 4 2005</u> Time: _____ Receiving Nurse Initials _____

(S)ubjective: "I think I have diverticulitis. Had this before and they said they thought that's what it is."

(O)bjective (V/S): T: 97⁷ P: 78 R: 18 BP: 100/80 WT: 185

At 9 AM to 40 abd pain in RL quad. State is having stool but he is constipated. Scant amt of bowel sounds noted in all four

(A)ssessment: Quadrants. Abd non distended. Non tender upon palpation. Hx + 3. Skn w/d to touch. Resp c clear. Ppt for alt w elimination

(P)lan: Colace \pm Bid \times 10 days
 MD appt qm

Refer to: MD/PA Mental Health Dental Daily Treatment
 CIRCLE ONE

Return to Clinic PRN

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

4/6/05

[Signature]

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: BARRY R. THOMAS Date of Request: APRIL 3, 2004
 ID # 178628 Date of Birth: 11-20-66 Location: 9B-71
 Nature of problem or request: SEVERE ABDOMINAL PAIN (LOWER RIGHT). FEELS LIKE APPENDICITIS. WAS TREATED FOR SAME SYMPTOMS IN OCTOBER 2002 AT VCE.

Barry R. Thomas
Signature

DO NOT WRITE BELOW THIS LINE

Date: 4/6/04
 Time: 930 AM ☒ PM
 Allergies: NKDA

Wt 172 Bp 120/80 P 61 R 20 T 97.8

RECEIVED

Date: _____
 Time: _____
 Receiving Nurse Initials _____

(S)ubjective: "I'm having pain in my abdomen mostly in my lower R side."
 W/m to Hcu. alert et oriented x3 Skin warm
 (O)bjective et dry to touch. Resp even et unlabored.
 C/o pain to @ right side of abdomen. Bowel sounds x4. Abd soft et nondistended. Denies constipation.
 (A)ssessment: No swelling or redness to R side.
 Non tender to touch.

Act in comfort

(P)lan:

Refers to MD

Rte if pain worsens before MD appt

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE ☒ EMERGENCY ☐

If Emergency was PHS supervisor notified: Yes ☐ No ☐

Was MD/PA on call notified: Yes ☐ No ☐

D Scott

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



INFIRMARY NURSING PROGRESS NOTES

081304

Date Time

11/30/04

Waiver for CCC — R. E. Ock —
O-DC CCC CV dt no medication —
Lab ordered — R. E. Ock —

INMATE NAME (LAST, FIRST, MIDDLE)

Thomas, Barry

DOC#

178628

DOB

1/20/66

R/S

Wm

FAC.

East

Health Services Request Form

Inmate Name BARRY THOMAS Date of Request 4-9-03
 AIS No. 178628 Date of Birth 11-20-66 Housing Loc. 9A-55
 Nature of problem or request ABCESS ON UPPER-LEFT THIGH. I SAW THE DR. MONDAY 7th. AND HE SAID "IT ISN'T READY," THEN TOLD A NURSE "I'LL SEE HIM WEDNESDAY" — I NEVER GOT AN APPOINTMENT THOUGH.

Sign here for consent to be treated by health staff for the condition described above. Barry Thomas

Place this slip in Medical Box or designated area

APR 10 2003

DO NOT WRITE BELOW THIS LINE

Health Care Documentation

Subjective:

Objective: BP _____ P _____ R _____ T _____ WT _____

See
waiver

Assessment:

Plan:

Refer to: PA/Physician _____ Mental Health _____ Dental _____
 Education: _____

Protocol used: (specify) _____

Signature _____ Title _____ Time _____ Date _____

NAME- LAST	FIRST	MIDDLE	AIS #
Thomas	Barr		178628

PHYSICIAN'S PROGRESS NOTES

NAPHCARE
PHYSICIAN'S PROGRESS NOTES

DATE	TIME	NOTES MUST BE SIGNED BY PHYSICIAN
4-2-03	7:45 am	<p>wt. 168, 98⁶, 80, 20, 120/80. S/C</p> <p>1. 1/2 spirin bid to 1 kg. X four days</p> <p>0. 5cm erythema - 4cm, 1 indurated area over the medial aspect of L thigh. 0.5cm oozing with minimal bloody drainage.</p> <p>1/2 Abx in thigh - 2nd to 2nd not 3rd</p> <p>Ph: - Bactrim DS bid - Doxycycline 100mg bid X 10 days - Tylenol TID 1000mg - 4/9/03</p>
4/11/03		<p>WT. 171 BP 118/80 P 76 R16 T 98</p> <p>Flu Abx L thigh. + bloody purulent drainage</p> <p>Ph: - drainage - ceftriaxone Bactrim 1000mg - 4/14/03</p>
NAME - LAST		FIRST MIDDLE AIS #
Thomas		Barry 178628

VC007

PHYSICIAN'S PROGRESS NOTES

Na. hCare, Inc.

Health Services Request Form

Name BARRY R. THOMAS Date of Request 4-6-03
 A.S. No. 178628 Date of Birth 11-20-66 Housing Loc. 9A-55
 Nature of problem or request AN APPARENT SPIDER BITE ON UPPER-LEFT THIGH — APPEARS TO BE INFECTED.

Sign here for consent to be treated by health staff for the condition described above.

Barry R. Thomas

Place this slip in Medical Box or designated area

DO NOT WRITE BELOW THIS LINE

Health Care Documentation

Subjective: "I noticed this bite on my l upper thigh about a wk. ago. But, it didn't start looking red + hurting until Friday of last wk my leg is down to my knee red."

Objective: BP 120/80 P 80 R 20 T 98.6 WT 168

w/m ambulates to HCU in no apparent distress. Resp. reg. + ease. Skin wtd to touch. On l upper thigh appears a bite. Redness + hardness around area. Redness down leg almost to knee. Area is all hot to touch.

Assessment: Potential for alteration in comfort / skin integrity.

Plan: See MD today - for evaluation.

Refer to: PA/Physician

Mental Health

Dental

Education:

Explained to HIM to return to HCU by 8:30 am. for MD apph Verbalized understanding.

Protocol used: (specify) N/A

Signature K. Wilson

Title RN

Time 7:45 am Date 4/7/03

NURSES NOTES

NAPHCARE
HEALTH SERVICES REQUEST FORM

Print Name: BARRY THOMAS Date of Request: 10-19-02

ID#: 178628 Date of Birth: 11-26-66 Housing Location: 10B-39B

Nature of problem or request: ABDOMINAL PAIN

Sign here for consent to be treated by health staff for the condition described

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

Subjective: My Bowels have been not **HEALTH CARE DOCUMENTATION**

moved

Objective: BP 130/80 P 82 R 18 T 98.4

Amb to HCU in Nap. Clo" severe
abd Pain. "I just cant move
my bowel" clo nausea & appetite
No Vomiting. Thurs Passed a supp.
& soft Brown. stool but not enough.

Assessment:

Plan: Placed in infirmary to have privacy
& quiet rest room.
Fluids encouraged.

Refer to: PA/Physician Mental Health Dental

Signature: [Signature] Title: _____ Date: _____ Time: _____

NCO40

HEALTH SERVICES REQUEST FORM

NAPHCARE
HEALTH SERVICES REQUEST FORM

Print Name: BARRY THOMAS Date of Request: 10-14-02
 ID#: 178628 Date of Birth: 11-20-26 Housing Location: 10B/3EB
 Nature of problem or request: CONSTIPATION

Barry Thomas
 Sign here for consent to be treated by health staff for the condition described

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
 DO NOT WRITE BELOW THIS AREA

Subjective: I've been constipated for 6-7 days HEALTH CARE DOCUMENTATION

Objective: BP 130/92 P 88 R 18 T 99.6

Amb to Hcu in Nap. Holding stomach
 abd soft. "fullness" noted on
 both sides. Not distended No N or V.
 Temp 99.6

Assessment: All in health maintenance.

Plan: To see MD. 10-14-02
encouraged to drink 8 glasses of H₂O
all on time for P.M.
inmate education sheet given. verbalized
understanding of insts.

Refer to: ☒ PA/Physician ☐ Mental Health ☐ Dental

Signature: [Signature] Title: PR Date: 10-14-02 7:00 PM

NCO40

HEALTH SERVICES REQUEST FORM

HEALTH STATUS

Transferring Facility: KILBY

Date: 5-10-02

Time: 9:30

Allergies: NICK

Food Handler Approved Y (N)

Name: Thomas, Barry
 AIS: 17228
 Age: Date of Birth: 11-20-66
 Race: W Sex: M

Current Acute Conditions/Problems: [Signature]
 Chronic Conditions/ Problems: [Signature]

Current Medications- Name, Dosage, Frequency, Duration:
 Acute short term medications: [Signature]

Chronic Long Term Medications: [Signature]

Chronic Psychotropic Medications: [Signature]

Current Treatments: [Signature]
 Follow up care Needed: [Signature]

Last PPD: 3-15-01 Results: [Signature] mms Last Physical: 3-15-01

Chronic Clinics: [Signature]

Specialty Referrals: [Signature]

Significant Medical History: Migraine H/A

Physical Disabilities/Limitations: [Signature]

Assistive Devices/Prosthetics: [Signature] Glasses: N Contacts: N

Mental Health History/Concerns: [Signature]

Substance abuse Y/N: Alcohol Y/N: Drugs Y/N:
 Hx Suicide Attempt Date: / /
 Hx Psychotropic Medication:
 Previous Psychiatric Hospitalizations:
 Signature/Title/Date: [Signature] 5/10

Transfer Reception Screening
 Date: 7/17/02 Time: 2:05 pm
 S: Current complaint: Needs annual Phys Exam
 Current medications/Treatments: None
 Physical Appearance/Behavior: (R) scar tattoo
 Deformities: Acute/Chronic: NONE
 P: 96 R: 20 B/P: 112/72
 A: Knowledge deficit
 P Disposition (Instructions: Check or circle as appropriate)
 [X] Routine sick call Instructions given
 Emergency referral
 HIV/TB Instructions given
 Physician referral
 Urgent / Routine
 Medication Evaluation
 Work/Program Limitation
 Special Housing
 Specialty Referrals
 Chronic Clinics
 Mental Health
 OTHER
 Infirmary Placement

Receiving Facility: VCF
 Signature/Title: [Signature] 7/17/02

INTRASYSTEM TRANSFER FORM

HEALTH STATUS

Transferring

Facility: CFDate: 4-16-02Time: 2430

Allergies

Food Handler Approved (Y) NName Thomas BarryAIS 178628Age 35Date of Birth 11-20-66Race WSex M

Current Acute Conditions/Problems:

Chronic Conditions/ Problems: Bipolar Disorder, migraines, headache

Current Medications- Name, Dosage, Frequency, Duration:

Acute short term medications

Chronic Long Term Medications

Chronic Psychotropic Medications

Current Treatments:

Follow up care Needed as neededLast PPD 3-15-01 Results 7 mms Last Physical 3-12-01 3/15/01

Chronic Clinics

Specialty Referrals

Significant Medical History

Physical Disabilities/Limitations

Assistive Devices/Prosthetics

Glasses

Contacts

Mental Health History/Concerns

Substance abuse Y/N

Alcohol Y/N

Drugs Y/N

Hx Suicide Attempt Date / /

Hx Psychotropic Medication

Previous Psychiatric Hospitalizations

Signature/Title/Date

Barry, B

Transfer Reception Screening

Date / / Time am pm

S: Current complaint

Current medications/Treatments

O Physical Appearance/Behavior

Deformities: Acute/Chronic

T P R B/P

A

P Disposition (Instructions: Check or circle as appropriate)

Routine sick call Instructions given

Emergency referral

HIV/TB Instructions given

Physician referral

Urgent / Routine

Medication Evaluation

Work/Program Limitation

Special Housing

Specialty Referrals

Chronic Clinics

Mental Health

OTHER

Infirmary Placement

Receiving Facility:

Signature/ Title:

FAS RASYSYSTEM TRANSFER FORM

HEALTH STATUS

Transferring
Facility:

KILBY

Name: Thomas, Barry
Number: 178628 Race: B ☒ W ☐ H ☐ Other
Age: _____ Date of Birth: 11/20/66 Sex: ☒ M ☐ FDate: 3/7/02Time: _____ AM ☐ PM ☐Allergies: NKA

Food Handler Approved: Y / N

Current Acute Conditions/Problems: ☒Chronic Conditions/ Problems: ☒

Current Medications - Name, Dosage, Frequency, Duration:

Acute Short-term Medications: ☒Chronic Long-term Medications: ☒Chronic Psychotropic Medications: ☒Current Treatments: ☒Follow-up Care Needed: ☒Last PPD: 3-15-01 Results ☒ mmsLast Physical: 3/1/01Chronic Clinics: ☒

Specialty Referrals: _____

Significant Medical History: Migraine H/APhysical Disabilities/Limitations: ☒Assistive Devices/Prosthetics: ☒Glasses: ☒Contacts: ☒

Mental Health History/Concerns:

Substance Abuse: Y / N

Alcohol: Y / N

Drugs: Y / N

Hx Suicide Attempt: Date: 1/1/

Hx Psychotropic Medication

Previous Psychiatric Hospitalizations

Signature and Title

Date: 3/7/01

TRANSFER RECEPTION SCREENING

Date: 3/18/02 Time: 9:00 AM ☐ PM ☒S: Current Complaint: NoneCurrent Medications/Treatment: NoneWT 174O: Physical Appearance/Behavior: tattoo TRarmDeformities: Acute/Chronic: NoneT 92 P 84 R 20 B/P 120/80

A: _____

Receiving
Facility:UC4

P: Disposition: (Instructions: Check or circle as appropriate)

- ☒ Routine, Sick Call
☐ Instructions Given
☐ Emergency Referral
☐ HIV/TB Instruction Given
☐ Physician Referral:
☐ Urgent / Routine
☐ Medication Evaluation
☐ Work/Program Limitation
☐ Special Housing
☐ Specialty Referrals
☐ Chronic Clinics
☐ Mental Health
☐ OTHER
☐ Infirmary Placement

Other: _____

C. Barnes, MD

PHS 7100

NAPHCARE
HEALTH SERVICES REQUEST FORM

Print Name: BARRY R. THOMAS Date of Request: JULY 15, 2002

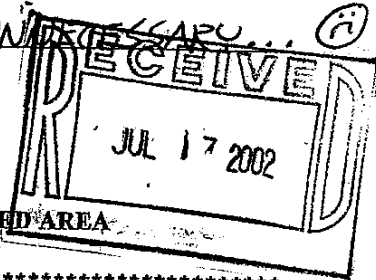
ID#: 178628 Date of Birth: 11-20-66 Housing Location: 10B-39B

Nature of problem or request: INFECTED TOE — BEGAN WITH INGROWN NAIL; WARM SALTY WATER AND ANTIBIOTIC OINTMENT APPLIED DAILY FOR THREE WEEKS, ONLY FOR SWELLING AND REDNESS TO WORSEN. WOULD NOT BOTHER YOU IF UNNECESSARY... (P)

Barry R. Thomas

Sign here for consent to be treated by health staff for the condition described

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
 DO NOT WRITE BELOW THIS AREA



Subjective: "Thought I had an ingrown toenail - removed it but now it's worse"

7/72 Objective: BP 120/80 P 96 R 20 T 98.4

w/m to HCU E above C/O - assess of R great toe reveals severe redness, edema, yellowish drainage

Assessment:

Alt comfort

Plan:

appt. c. M.D.

Refer to: ☒ PA/Physician ☐ Mental Health ☐ Dental

Signature: [Signature] Title: [Signature] Date: 7/17/02 Time: 2010

NCO40

HEALTH SERVICES REQUEST FORM

INMATE REQUEST SLIP

Name BARRY R. THOMAS Quarters K-71 Date 9-26-99AIS # 178628

- () Telephone Call () Custody Change () Personal Problem
 () Special Visit () Time Sheet () Other ☒

Briefly Outline Your Request - Then Drop In Mail Box

DEAR MADAM:

I'M WRITING TO REQUEST AN APPOINTMENT
WITH DR. CAMPBELL THIS WEEK, IF SUCH
MIGHT FIT HIS SCHEDULE. THANK YOU
VERY MUCH.

Barry R. Thomas

Do Not Write Below This Line - For Reply Only

9/28/99 - no show for etc. mileage

Approved

Denied

Pay Phone

Collect Call

Request Directed To: (Check One)

() Warden

() Deputy Warden

() Captain

() Classification Supervisor

() Legal Officer - Notary Public

() Record Office

N176

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: Barry Thomas Date of Request: 11/2/97

ID #: 178628 Date of Birth: 11/20/66 Housing Location: KCB-19

Nature of problem or request: Problem with dizziness, chest pain.
Blood pressure checked high Sat. Nov. 1st. Instructed
by nurse Giles to be a sick call Monday, Nov. 3rd.

I consent to be treated by health staff for the condition described.

Barry Thomas
SIGNATURE

**PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA**

HEALTH CARE DOCUMENTATION

Subjective: Pain in my chest + left arm from
time to time - some nausea + dizziness
Just started 3wks ago

Objective: BP 122/92 P 100 R 20 T 97.6

Lungs clear
HR rapid but regular
Skin warm dry & pink

Assessment:

EKG done

Plan:

See Dr.

Refer to: ☐ PA/Physician ☐ Mental Health ☐ Dental

Signature: Dalleson Title: RN Date: _____ Time: _____

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: Barry R. Thomas Date of Request: 10-27-97

ID #: 178628 Date of Birth: 11-20-66 Housing Location: KCB-19

Nature of problem or request: periodic spells of dizziness, shortness of breath, weakness, mild pressure in chest, and nausea for the past ten days. (EKG was done on 10-20-97 with no indication of irregularities; problems persist however)
I consent to be treated by health staff for the condition described.

Barry R. Thomas
SIGNATURE

**PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA**

HEALTH CARE DOCUMENTATION

Subjective:

I have been experiencing hypertension in chest, heart starts racing, I think I'm having anxiety attacks

Objective: BP

120/80 P 80 R 20 T 99°

State had EKG last wk on 10/20/97 when I had this attack before - EKG to review

Assessment:

Plan:

Review C PR m/10/28/97

Refer to: PA/Physician Mental Health Dental

Signature:

m/10/28/97 Title: LP Date: 10/28/97 Time: 0830

CORRECTIONAL MEDICAL SERVICES

INTERDISCIPLINARY PROGRESS NOTES

Patient
Name

Thomas, Larry

I.D. #

178628

Institution

KILBY

DATE	TIME	NOTES	SIGNATURE
8/15/97		pb	
11/3/97	87	pb hcn = 3 w/ the light-headedness, SUB, rapid HR + clp - sharp - non radiating. He readily admits to depression, anxiety anxiety - used to be on anti-depressants of cont @. Thyroid ✓ no nodes P-R-T-A. Jundi @ Chest CNS ✓ NSA no @ or PVC's BP 130/80 CNS - tense, anxious M Anxiety / Depression P1. Reassured M R given She PR -	
			The Surge

CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM

Print Name: Barry R. Thomas Date of Request: 1-1-97
ID #: 178628 Date of Birth: 11-20-66 Housing Location: KCB-19

Nature of problem or request: I need an appointment for an eye exam -
my vision is progressively getting poorer and is affecting
my work as a pressman in the print shop.

I consent to be treated by health staff for the condition described. Thank you
Barry R. Thomas
SIGNATURE

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

HEALTH CARE DOCUMENTATION

Subjective: Eye DR

Objective: BP 110/70 P 72 R 20 T 98.3
VLA 20/40 OU

Assessment:

Plan: Eye list / Dr. Biles

Refer to: ☐ PA/Physician ☐ Mental Health ☐ Dental

Signature: Dr. Biles Title: MD Date: 1/2/97 Time: 0915

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: Barry R. Thomas Date of Request: 7/25/96

ID #: 178628 Date of Birth: 11/20/66 Housing Location: KCB-134

Nature of problem or request: Severe ear pain - right ear. Was seen
by doctor Wed. 24th; he prescribed drops and antibiotics.
However, I need something for pain.

I consent to be treated by health staff for the condition described.

Barry R. Thomas
SIGNATURE

**PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA**

HEALTH CARE DOCUMENTATION

Subjective: Something for Pain

Objective: BP 140/80 P 72 R 20 T 99.2

24h. Labs 11 given ↑ Temp
presently on Cortisporin 975 & Tylenol 100mg bid
Assessment: Seen by DR 7/24/96 Ear Infected

Plan: Discharge to DR in file

Refer to: ☐ PA/Physician ☐ Mental Health ☐ Dental

Signature: mfile Title: 4th Date: 7/26/96 Time: 0555

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: Barry R. Thomas Date of Request: 7/1/96

ID #: 178628 Date of Birth: 11/20/66 Housing Location: M-47

Nature of problem or request: hearing loss in right ear - excessive
wax build-up - w/ dry sore

I consent to be treated by health staff for the condition described.

Barry R. Thomas
SIGNATURE

**PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA**

HEALTH CARE DOCUMENTATION

Subjective: rt. Ear hurting

Objective: BP 130/74 P 80 R 20 T 98.0

Assessment:

Plan: 20 sec Dr. M. Miles, r

Refer to: ☐ PA/Physician ☐ Mental Health ☐ Dental

Signature: Miles Title: cp Date: 7/24/96 Time: 0630

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: Barry R. Thomas Date of Request: 8/8/96
ID #: 178628 Date of Birth: 11/20/66 Housing Location: KCB-134
Nature of problem or request: Need eye exam (vision extremely
poor)

I consent to be treated by health staff for the condition described.

Barry R. Thomas
SIGNATURE

**PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA**

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP _____ P _____ R _____ T _____

8/9 0-70 show you S/C 1 A. B. King

Assessment:

Plan:

Refer to: _____ PA/Physician _____ Mental Health _____ Dental

Signature: _____ Title: _____ Date: _____ Time: _____

INTRASYSTEM TRANSFER FORM

HEALTH STATUS

Transferring
Facility: BCCFName: Thomas BarryNumber: 178628 Race: B ☒ W ☐ H ☐ OtherAge: _____ Date of Birth: 11/20/66 Sex: ☒ M ☐ FDate: 7/23/96

Time: _____ AM PM

Allergies: NKA

Food Handler Approved: Y / N

Current Acute Conditions/Problems: _____

Chronic Conditions/ Problems: _____

Current Medications - Name, Dosage, Frequency, Duration:

Acute Short-term Medications: _____

Chronic Long-term Medications: _____

Chronic Psychotropic Medications: _____

Current Treatments: _____

Follow-up Care Needed: _____

Last PPD: 11-28-95 Results 0 mmsLast Physical: 11/27/95

Chronic Clinics: _____

Specialty Referrals: _____

Significant Medical History: _____

Physical Disabilities/Limitations: _____

Assistive Devices/Prosthetics: _____

Glasses: _____

Contacts: _____

Mental Health History/Concerns:

Substance Abuse: ☒ Y ☐ N

Alcohol: Y / N

Drugs: ☒ Y ☐ NHx Suicide Attempt: Date: 1/1/

Hx Psychotropic Medication

Previous Psychiatric Hospitalizations

Signature and Title: AppointerDate: 7.14.96

TRANSFER RECEPTION SCREENING

Date: 7/23/96 Time: 8:00 AM PMS: Current Complaint: 0Current Medications/Treatment: 0

O: Physical Appearance/Behavior:

Has not been seen
in 2 weeks

Deformities: Acute/Chronic: _____

T _____ P _____ R _____ B/P _____

A: _____

Receiving
Facility: BCCF

P: Disposition: (Instructions: Check or circle as appropriate)

Routine, Sick Call

Instructions Given

Emergency Referral

HIV/TB Instruction Given

Physician Referral:

Urgent / Routine

Medication Evaluation

Work/Program Limitation

Special Housing

Specialty Referrals

Chronic Clinics

Mental Health

OTHER

Infirmary Placement

Other: _____

Signature and Title: Kate Barry 7/23/96

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: Barry R. Thomas Date of Request: 7/18/96

ID #: 178628 Date of Birth: 11/20/66 Housing Location: 22-58

Nature of problem or request: Need eye exam. (vision has gotten
excessively poor recently, especially in left eye,
for some reason of which I do not understand)

I consent to be treated by health staff for the condition described.

Barry R. Thomas
SIGNATURE

**PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA**

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP _____ P _____ R _____ T _____

Assessment:

Plan:

Refer to: _____ PA/Physician _____ Mental Health _____ Dental

Signature: _____ Title: _____ Date: _____ Time: _____

CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM

Print Name: Barry R. Thomas Date of Request: 1-18-95
ID #: 178628 Date of Birth: 11-20-66 Housing Location: 22-40
Nature of problem or request: Pain in lower back for past three
days

I consent to be treated by health staff for the condition described.

Barry R. Thomas
SIGNATURE

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

HEALTH CARE DOCUMENTATION

Subjective: Lower back pain

Objective: BP 120/60 P 64 R 20 T 98°

C/O lower back pain for the past three days. C/O
unable to bend over comfortably. Resp reg & even. Skin
W/D D. Much
Assessment: Alteration in Comfort

Plan:
MD

Refer to: PA/Physician Mental Health Dental

Signature: LS Brown Title: RN Date: 1/18/96 Time: 2350

PATIENT NOTES / PHYSICIAN ORDERS

DATE	TIME	PATIENT NOTES	DATE ORDERED	TIME ORDERED	PHYSICIAN ORDERS
01-14-96		2-8-95 Back pain Flexion = pain Ext - OK Pull muscle back Knee Motion good but x50			1) Imipramine 50mg p.o. qhs x 2 wks; then ↑ 75 x 2 wks; then ↑ 100 x 2 wks; then ↑ 125 x 2 wks; then ↑ to 150mg p.o. qhs x 3 mos. 2) D/C indoral. 3) D/C midrin. 4) RTC - 3 mos. R. Cooper MD
			5/10/95		D/C Imipramine RTC one mo Bucklain MD
			6/9/95		510 10/11/95 RTC 3 mos Bucklain MD C. Smith MD
BULLOCK HEALTH CARE UNIT					
INMATE NAME (LAST, FIRST, MIDDLE) Thomas, Barry			DATE OF BIRTH 11/20/66		AGE 28 R/S WM ID# 178628

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Motrin 600mg po tid PR X 14	4A	[Handwritten signatures and initials]																													
Start Date: 6-5-07	Prescriber: Darbonne															RX #:															
Stop Date: 6-19-07	RX #:																														
Flexeril 10mg po tid PR X 14	4A	[Handwritten signatures and initials]																													
Start Date: 6-5-07	Prescriber: Darbonne															RX #:															
Stop Date: 6-19-07	RX #:																														
Bengay oint Bid PR X 5	4A	[Handwritten signatures and initials]																													
Start Date: 6-5-07	Prescriber: Darbonne															RX #:															
Stop Date: 6-19-07	RX #:																														
Motrin 400mg po PRN BID X 2 days	4A	[Handwritten signatures and initials]																													
Start Date: 6/26/07	Prescriber: Floyd															RX #:															
Stop Date: 6/28/07	RX #:																														
Naprosyn 375mg ± Tid X 30d	4A	[Handwritten signatures and initials]																													
Start Date: 6/28/07	Prescriber: Dr. Darbonne															RX #:															
Stop Date: 7/28/07	RX #:																														
Robaxin 500mg ± Bid X 10 days	4A	[Handwritten signatures and initials]																													
Start Date: 6/28/07	Prescriber: Dr. Darbonne															RX #:															
Stop Date: 7/18/07	RX #:																														
Diagnosis	Nurse's Signature: [Handwritten]															Initial: [Handwritten]															
Allergies: NSA	Nurse's Signature: [Handwritten]															Initial: [Handwritten]															
Housing Unit: 178628	Nurse's Signature: [Handwritten]															Initial: [Handwritten]															
Patient ID Number: 178628	Nurse's Signature: [Handwritten]															Initial: [Handwritten]															
Patient Name: Thomas Barry	Nurse's Signature: [Handwritten]															Initial: [Handwritten]															
Date of Birth: 1/20-66	Nurse's Signature: [Handwritten]															Initial: [Handwritten]															

Tylenol 1gmpo
x 1 dose now

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Stop Date:	6/30/07										RX #:																				

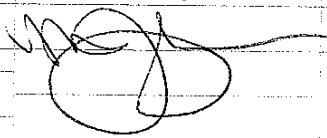
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Start Date:											Prescriber:																				
Stop Date:											RX #:																				

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
Allergies: NKA					1. Discontinued Order
Housing Unit: 178 628					2. Refused
Patient ID Number:					3. Patient out of room
Patient Name: Thomas Barry					4. Charted in ER
					5. Lock Down
					6. Self Administered
					7. Medication out of Stock
					8. Medication Error
					9. No Show
					10. Other

Date of Birth:

11/01/00

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
					1. Discontinued Order
Allergies: NLPA	<i>[Signature]</i>	cn	<i>[Signature]</i>	LS	2. Refused
	<i>[Signature]</i>	JK	<i>[Signature]</i>	WJ	3. Patient out of facility
Housing Unit:					4. Granted in Error
Patient ID Number: 178628					5. Locked Down
Patient Name:					6. Self Administered
Thomas Barry					7. Medication out of Stock
					8. Medication Held
					9. No Show
					10. Other
			Date of Sick:	11-20-66	

ERROR

Start Date: 12-13-2005

Prescriber: Darbouze, Jean

Stop Date: 01-11-2006

RX #: 250970433

PEROGESTIC \div
PO ~~120~~¹²⁰ PRN
576
X 30 days

Hour	1	2	3	4	5
YA	9	10	5	5	5
9A	9				
4°C					

Start Date: 12-9-05

Prescriber: Sarbouzi

Stop Date: 1-9-06

RX 註:

Nurse's Signature

Initial

Nurse's Signature _____

[initia]

Documentation Codes

Alergies

NKDA

5.5 ~~minutes~~ ^{hr}

5/15

Claudia A

2

Housing Unit:

Population

Patient ID Number:

178628

Patient Name: _____

Date of Birth:

11-20-66

1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

PHS057

Facility Name: <u>EASTERLUND</u>		Month/Year of Charting: <u>12/05</u>																																																																																																																														
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Housing Unit:		Nurse's Signature: <u>Pratt</u> Initial: <u>✓</u>																																																																																																																														
Patient ID Number: <u>178628</u>		Nurse's Signature: <u>Hamilton</u> Initial: <u>✓</u>																																																																																																																														
Patient Name: <u>THOMAS RAEEN</u>		Date of Birth:																																																																																																																														

Facility Name: <u>Easterburg</u>		Month/Year of Charting: <u>Nov 05</u>																														
Tylenol 1gm po bid x 5 d	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	4a	→ 8 5/16 ←																														
	4p	→ 8 1/2 ←																														
Start Date: <u>11-14-05</u>		Prescriber: <u>Darbone/CS</u>																														
Stop Date: <u>11-19-05</u>		RX #:																														
Feldene 20mg po qam x 14 days PR	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	4p	→ 8 5/16 ←																														
Start Date: <u>11-18-05</u>		Prescriber: <u>Darbone</u>																														
Stop Date: <u>12-2-05</u>		RX #:																														
Tylenol 1gm po tid PR x 14 days	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	4A	→ 8 5/16 ←																														
	9A	→ 8 5/16 ←																														
Start Date: <u>11-18-05</u>		Prescriber: <u>Darbone</u>																														
Stop Date: <u>12-2-05</u>		RX #:																														
Flexeril 10mg po tid PR x 7 days	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	4A	→ 8 5/16 ←																														
	9A	→ 8 5/16 ←																														
Start Date: <u>11-18-05</u>		Prescriber: <u>Darbone</u>																														
Stop Date: <u>11-25-05</u>		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Start Date:		Prescriber:																														
Stop Date:		RX #:																														
Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes																											
	<u>Darbone</u>	<u>S</u>	<u>J. Ewing</u>	<u>JE</u>	1. Discontinued Order 2. Refused 3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock 8. Medication Held 9. No Show 10. Other																											
Allergies																																
Housing Unit:																																
Patient ID Number: <u>175628</u>																																
Patient Name: <u>Theresa Barry</u>																																
			Date of Birth:																													

PHS060

370703

[illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

PHS061

MEDICATION ADMINISTRATION RECORD

07/01/2004

(EAS-474) EASTERLING CORR. FACILITY

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
PSYLLIUM (REGULID) POW 3.4GM IN 10-OZ LIQUID BY MOUTH DAILY *KEEP ON PERSON*																																					
RX: 5472954 ANDERSON, M.D., VICTORIA, MD START - 04/10/2004 STOP - 07/08/2004																																					
LOPID (LIPID) 600MG TAB TAKE 1 TABLET(S) BY MOUTH TWICE DAILY *KEEP ON PERSON*																																					
RX: 5501373 COOLEY, N.P., CIGELIA, NP START - 04/17/2004 STOP - 07/15/2004																																					
Lopid 600mg TAB PO BID X 90 days 6-26-2004 - 9-24-2004 Discontinued																																					

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR	07/01/2004	THROUGH	07/31/2004
Physician	COOLEY, N.P., CIGELIA	Telephone No.	Medical Record No.
Att. Physician		Att. Telephone	
Bergs	NO KNOWN DRUG ALLERGY	Rehabilitative Potential	
Diagnosis			
Medication	Medication Number	Complete Entries Checked:	
PATIENT	By: <i>[Signature]</i>	Time: <i>Am</i>	Date: 6-2
THOMAS, NANCY	PATIENT CODE	ROOM NO.	BED #
	178628	1	17

(EAS-474) EASTERLING CORR. FACILITY

5074

[illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

PHS063

MEDICATION ADMINISTRATION RECORD

05/01/2004

(EAS-474) EASTERLING CORR. FACILITY

5051

[illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR		05/01/2004	THROUGH	05/31/2004
Physician	COOLEY, N. P., CECILIA			Telephone No.
Alt. Physician				Alt. Telephone
Allergies	NO KNOWN DRUG ALLERGY			Rehabilitative Potential

Diagnosis

Medicaid Number:		Medicare Number:		Complete Entries Checked:	
				By: <i>D. Palmer</i>	Date: <i>4-21-2009</i>
PATIENT				PATIENT CODE	ROOM NO.
THOMAS, DARYL				178628	1
				BED	FACILITY CODE
					EAS-474

PHS064

MEDICATION ADMINISTRATION RECORD

metamucil 3.4gm in KOP
10oz H₂O po qd KOP
X 3mths 4/9/04 → 7/9/04

Lopid 600mg b.i.d. 4AK
X 90 days KOP
4-15-04 → 7-15-04 Coolidge

Barry Thomas → # 600 4/26 Barry Thomas

MEDICATIONS HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 4/04 THROUGH 4/04

Physician: Anderson Telephone No. Medical Record No.

Alt. Physician: Alt. Telephone

Allergies: NIKOIA Rehabilitative Potential

Diagnosis

Master Window Notes Title Complete Entries Checked

By: B. Macmillan Title: Lr Date: 4/9/04

PATIENT: Thomas, Barry PATIENT CODE: 178675 ROOM NO.: DNP BED: FACILITY CODE: Ent

MEDICATION ADMINISTRATION RECORD

[illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 47-63

THROUGH 0-30-03

Physician	Telephone Number	Inmate No.
Alt. Physician	Alt. Telephone	
Allergies	Rehabilitative Potential	
Diagnosis		

Diagnosis									
Medicaid Number		Medicare Number		Complete Entries Checked		Title: <i>LR</i>		Date: <i>4/9/03</i>	
By: <i>Thomson</i>		By: <i>Barry</i>		By: <i>178628</i>		PATIENT CODE: <i>54</i>		ROOM NO.	
PATIENT: <i>Thomson Barry</i>		PATIENT CODE: <i>178628</i>		ROOM NO. <i>54</i>		BED		FACILITY CODE	

[illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR		THROUGH	
Physician	Barbours	Telephone Number	Inmate No.
Alt. Physician	November 2002	Alt. Telephone	
Alt. As		Rehabilitative Potential	
Diagnosis			
PKDA			
Medicaid Number	Medicare Number	Complete Entries Checked	
		By: A. K. K. K.	Title: R
PATIENT	Thomas Barry	PATIENT CODE	ROOM NO.
		178628	BED
			FACILITY CODE
			102

MEDICATION ADMINISTRATION RECORD



MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Motrin $\frac{1}{2}$ tsp PO in liquid per q day 1 wk Msking / AMark 10-15-02 - 10-22-02	0900 0900																																
Magnitrate po x 1 bottle New today Msking / AMark xM 10-15-02																																	
Dulcolax suppxl per rectum today Msking / AMark xB 10-15-02	3P																																
Dulcolax tabs $\frac{1}{2}$ po this pm x1 Ms King / AMark xPR 10-15-02	3P																																
Enema x 1	1215																																
Darbuze/CH 10-20-02 Tylenol tabs III PO TID PRN x 3 days	4A 9A 4P																																
Darbuze/CH 10-20-02/ Maalox II tabs PO TID x 3 days	4A 9A 4P																																
Darbuze/CH 10-20-02/ Tylenol 325mg III PO TID PRN x 5 days 10/22/02 - 10/26/02 Darbuze/CH	4A 9A 4P																																
Maalox II PO TID PRN x 5 days 10/22/02 - 10/26/02 Darbuze/CH	4A 9A 4P																																

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR	10-15-02	THROUGH	10-31-02
Physician	Dr. Darbuze	Telephone Number	
Alt. Physician	Ms King / Dr. Benkette	Alt. Telephone	
Allergies	NKA	Rehabilitative Potential	
USIS			
Medicaid Number		Complete Entries Checked	
Medicare Number		By:	Thomas Barry
PATIENT	Thomas Barry	PATIENT CODE	178628
		ROOM NO.	
		BED	
		FACILITY CODE	VCF

MEDICATION ADMINISTRATION RECORD



MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Colace 100mg PO QD x 2 weeks 10-24-02 11-7-02	44																																
Dr. Darabony, Alexander R. Mantac 150mg PO BID x 2 weeks 10-24-02 11-7-02	44 44																																
Dr. Darabony, Alexander R.																																	

BioReference
LABORATORIES

104994572-6 THOMAS, BARRY

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O
C
T
O
REASTERLING CORR. FACILITY
200 WALLACE DR.
CLIO, AL 36017
(334) 397-4471 (A0113-4)

FX

THOMAS, BARRY

THOMAS, BARRY

THOMAS, BARRY

THOMAS, BARRY

-FINAL- Original Report 07/03/2007

NAME

THOMAS, BARRY

PATIENT I.D. / ROOM NO.

178628

DOCTOR / GROUP NAME

DR. DARBOUZE

LAB I.D. NO.

104994572

DATE COLLECTED

07/02/2007

DATE RECEIVED

07/03/2007 09:45

DATE OF REPORT

7/3/2007 14:49

AGE

40

SEX

Y M

Test Description	Result	Abnormal	Reference Range
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Comment :

NONFASTING

-----* CHEMISTRY *-----

Total Protein	7.8		5.9-8.4	gm/dl
Albumin	5.0		3.2-5.2	gm/dl
Globulin	2.8		1.7-3.7	gm/dl
A/G Ratio	1.8		1.1-2.9	
Glucose		116 HI	70-109	mg/dL
Sodium	145		133-145	mmol/L
Potassium	4.2		3.3-5.3	mmol/L
Chloride	104		96-108	mmol/L
CO2	23		21-29	mmol/L
BUN	11		7-25	mg/dl
* Creatinine	1.0		0.6-1.3	mg/dl
BUN/Creat Ratio	11		10-28	
Calcium	9.9		8.4-10.4	mg/dl
Uric Acid	5.5		2.4-7.0	mg/dl
Iron	117		30-160	mcg/dl
Bilirubin, Total	0.4		0.1-1.0	mg/dl
LDH	204		94-250	u/l
Alk Phos	72		39-120	u/l
AST (SGOT)	22		< 37	u/l
Phosphorous	3.4		2.6-4.5	mg/dl
ALT (SGPT)	21		< 40	u/L
G-GTP	17		7-51	u/L

* GFR, Estimated = 87.68 mL/min/1.73m2

Continued on Next Page

Page: 1

James Weissberger, M.D.
481 EDWARD H. ROSS DR.
ELMWOOD PARK, NJ 07407
1-800-229-LABS

PHS070

BioReference
LABORATORIES

104994572-6 THOMAS, BARRY

THOMAS, BARRY

THOMAS, BARRY

THOMAS, BARRY

THOMAS, BARRY

-FINAL- Original Report 07/03/2007

NAME THOMAS, BARRY		PATIENT I.D. / ROOM NO. 178628		DOCTOR / GROUP NAME DR. DARBOUZE	
LAB I.D. NO. 104994572	DATE COLLECTED 07/02/2007	DATE RECEIVED 07/03/2007 09:45	DATE OF REPORT 7/3/2007 14:49	AGE 40	SEX Y M

Test Description	Result	Abnormal	Reference Range
------------------	--------	----------	-----------------

-----* CARDIOVASCULAR/LIPIDS *

Cholesterol	175		< 200 mg/dl
Triglycerides	140		< 151 mg/dl
HDL CHOL., DIRECT	60		>35 mg/dl
HDL as % of Cholesterol	34 (> 25)	BELOW AVERAGE RISK	%
Chol/HDL Ratio	2.92 (<4.2)	BELOW AVERAGE RISK	
LDL/HDL Ratio	1.45		0-3.55
LDL Cholesterol	87		< 100 mg/dL

-----* HEMATOLOGY *

WBC	11.7		3.40-11.80 x10 (3)
RBC	5.9		4.20-5.90 x10 (6)
HGB		17.9 HI	12.3-17.0 gm/dl
HCT		53.5 HI	39.3-52.5 %
MCV	90.2		80.0-100.0 FL
MCH	30.2		25.0-34.1 pg
MCHC	33.5		30.0-35.0 gm/dl
RDW	13.4		10.9-16.9 %
POLYS	77		36-78 %
POLYS - COUNT, ABS	9009		1224-9204
LYMPHS	15		12-48 %
LYMPHS - COUNT, ABS	1755		408-5664
EOS	1		0-8 %
EOS - COUNT, ABS	117		34-944
BASOS	0		0-2 %
BASOS - COUNT, ABS	0		0-236
MONOS	7		0-13 %
MONOS - COUNT, ABS	819		170-1416
Platelet Count	250		144-400 x10 (3)

Continued on Next Page

Page: 2

A 7/9/07

James Welsberger, M.D.

481 EDWARD H. ROSS DR.
ELMWOOD PARK, NJ 07407
1-800-229-1 ARS

PHS071

BioReference
LABORATORIES

104994572-6 THOMAS, BARRY

THOMAS, BARRY

THOMAS, BARRY

THOMAS, BARRY

THOMAS, BARRY

-FINAL- Original Report 07/03/2007

NAME THOMAS, BARRY		PATIENT I.D. / ROOM NO. 178628		DOCTOR / GROUP NAME DR. DARBOUZE	
LAB I.D. NO. 104994572	DATE COLLECTED 07/02/2007	DATE RECEIVED 07/03/2007 09:45	DATE OF REPORT 7/3/2007 14:49	AGE 40	SEX Y M

Test Description	Result	Abnormal	Reference Range
------------------	--------	----------	-----------------

-----* MISCELLANEOUS *-----

PSA 3rd.GEN.	0.731	<4.0 ng/mL
--------------	-------	------------

The PSA assay should not be the only test used for diagnostic purposes. Additional evaluation using DRE, ultrasound, TUR or similar procedures may be used for this purpose. Predictions of disease recurrence should not be based solely upon values obtained from serial PSA values obtained on the patient.
PSA method: Roche Diagnostics/electrochemiluminescence Immunoassay.

Final Report

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7/9/07

James Weisberger, M.D.

 481 EDWARD H. ROSS DR.
ELMWOOD PARK, NJ 07407
1-800-229-LABS

PHS072

AL

DEPARTMENT OF CORRECTIONS

RADIOLOGY SERVICES REQUEST AND REPORT

INSTITUTION: EasterlingName: THOMAS - BarryState ID No.: 178 625DOB: 11-20-66Race: WSex: M

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP <u>D. Payne</u>	Date of request <u>7-2-07</u>	Time of request	Routine <u>X</u>	Priority	Transportation or special needs
HISTORY/DIAGNOSIS: <u>* Best to Pt ability *</u>					

X-RAY REQUEST			
ABDOMEN/ACR		FINGERS	NAVICULAR VIEW
ACROMIO-CLAVICULAR JOINTS (W/O WEIGHT)		FOOT	ORBITS
ANKLE		HAND	OS CALCIS (HEEL)
CERVICAL SPINE	<u>X</u>	HIP <u>RT- LT.</u>	PELVIS
CHEST PA / LATERAL		HUMERUS	RADIUS/ULNA
COCCYX		KNEE	RIBS
CONE DOWN SELLA TURCICA	<u>X</u>	LUMBAR SPINE	SACRO-ILIAC JOINTS
ELBOW		MANDIBLE	SCAPULA
FACIAL BONES		MAXILLA	SHOULDER
FEMUR		NASAL BONES	SKULL
			SOFT TISSUE STUDIES
			STERNUM
			TEMPORO-MANDIBULAR JOINTS
			THORACIC SPINE
			TIBIA/FIBULA
			TOES
			WRIST
			ZYGOMA
			ZYGOMATIC ARCH

Thomas

REPORT

LUMBAR SPINE: There is slight scoliosis of the spine with the curve directed to the left. The curvature measures approximately 10 degrees. The vertebral body heights are maintained. No significant disc space narrowing is detected.
IMPRESSION: MILD SCOLIOSIS.

BOTH HIPs: The examination shows no evidence of recent fracture or other significant bony abnormality.
IMPRESSION: NEGATIVE STUDY.

D & T: 07-03-07 Thomas J. Payne, III, M.D./km Board Certified Radiologist (Signature on file)

RAY TECHNOLOGIST'S NAME (PRINT)

X-RAY TECHNOLOGIST'S SIGNATURE

DATE, TIME EXAM PERFORMED

DEMOGRAPHIC NAME (PRINT)

RADIOLOGIST SIGNATURE

DATE PRINTED

(TUE) JUL 3 2007 16:01/ST. 15:44/NO. 6312281537 P 8

FROM CANARA IMAGING

PHS073

BIOREFERENCE LABORATORIES

481 EDWARD H. ROSS DR. ELMWOOD PARK, NJ 07407
1-800-228-LABS

DOCTOR	EASTERLING CORR. FACILITY 200 WALLACE DR. CLIO, AL 36017 (334) 397-4471 (A0113-4)		DOB: 11/20/1966			
	-FINAL- Original Report 07/03/2007					
	NAME THOMAS, BARRY		PATIENT I.D./ROOM NO. 178628		DOCTOR / GROUP DR. DARBOUZE	
	LAB I.D. NO. 104994572	DATE COLLECTED 07/02/2007	DATE RECEIVED 07/03/2007 09:45	DATE OF REPORT 7/3/2007 12:30	AGE 40 Y	SEX M

Test Description	Result	Abnormal	Reference Range
------------------	--------	----------	-----------------

Comment :
NONFASTING

* CHEMISTRY *

Total Protein	7.8		5.9-8.4	gm/dl
Albumin	5.0		3.2-5.2	gm/dl
Globulin	2.8		1.7-3.7	gm/dL
A/G Ratio	1.8		1.1-2.9	
Glucose		116 HI	70-109	mg/dL
Sodium	145		133-145	mmol/L
Potassium	4.2		3.3-5.3	mmol/L
Chloride	104		96-108	mmol/L
CO2	23		21-29	mmol/L
BUN	11		7-25	mg/dl
* Creatinine	1.0		0.6-1.3	mg/dl
BUN/Creat Ratio	11		10-28	
Calcium	9.9		8.4-10.4	mg/dl
Uric Acid	5.5		2.4-7.0	mg/dl
Iron	117		30-160	mcg/dl
Bilirubin, Total	0.4		0.1-1.0	mg/dl
LDH	204		94-250	u/l
Alk Phos	72		39-120	u/l
AST (SGOT)	22		< 37	u/l
Phosphorous	3.4		2.6-4.5	mg/dl
ALT (SGPT)	21		< 40	u/L
G-GTP	17		7-51	u/L

* GFR, Estimated = 87.68 mL/min/1.73m2

Continued on Next Page

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James Weinberger
James Weinberger, M.D.
Laboratory Director

7/3/07

BIOREFERENCE LABORATORIES

481 EDWARD H. ROSS DR. ELMWOOD PARK, NJ 07407
1-800-228-LABS

D O C T O R	EASTERLING CORR. FACILITY 200 WALLACE DR. CLIO, AL 36017 (334) 397-4471 (A0113-4)		DOB: 11/20/1966			
	-FINAL- Original Report 07/03/2007					
	NAME		PATIENT ID. / ROOM NO.		DOCTOR / GROUP	
	THOMAS, BARRY		178628		DR. DARBOUZE	
LAB ID. NO.		DATE COLLECTED		DATE RECEIVED		DR. DARBOUZE
104994572		07/02/2007		07/03/2007 09:45		7/3/2007 12:30
				40 Y		M

Test Description	Result	Abnormal	Reference Range
------------------	--------	----------	-----------------

-----* CARDIOVASCULAR/LIPIDS *-----

Cholesterol	175		< 200 mg/dl
Triglycerides	140		< 151 mg/dl
HDL CHOL., DIRECT	60		>35 mg/dl
HDL as % of Cholesterol	34 (> 25)	BELOW AVERAGE RISK	%
Chol/HDL Ratio	2.92 (<4.2)	BELOW AVERAGE RISK	
LDL/HDL Ratio	1.45		0-3.55
LDL Cholesterol	87		< 100 mg/dL

-----* HEMATOLOGY *-----

WBC	11.7		3.40-11.80	x10(3)
RBC	5.9		4.20-5.90	x10(6)
HGB		17.9 HI	12.3-17.0	gm/dl
HCT		53.5 HI	39.3-52.5	%
MCV	90.2		80.0-100.0	FL
MCH	30.2		25.0-34.1	pg
MCHC	33.5		30.0-35.0	gm/dl
RDW	13.4		10.9-16.9	%
POLYS	77		36-78	%
POLYS - COUNT, ABS	9009		1224-9204	
LYMPHS	15		12-48	%
LYMPHS - COUNT, ABS	1755		408-5664	
EOS	1		0-8	%
EOS - COUNT, ABS	117		34-944	
BASOS	0		0-2	%
BASOS - COUNT, ABS	0		0-236	
MONOS	7		0-13	%
MONOS - COUNT, ABS	819		170-1416	
Platelet Count	250		144-400	x10(3)

Continued on Next Page

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James Walsberger
James Walsberger, M.D.
Laboratory Director

7/6/07
[Signature]

BIOREFERENCE LABORATORIES

481 EDWARD H. ROSS DR. ELMWOOD PARK, NJ 07407
1-800-228-LABS

D O C T O R	EASTERLING CORR. FACILITY 200 WALLACE DR. CLIO, AL 36017 (334) 397-4471 (A0113-4)		DOB: 11/20/1966						
	-FINAL- Original Report 07/03/2007								
	NAME		PATIENT I.D. / ROOM NO.		DOCTOR / GROUP				
	THOMAS, BARRY		178628		DR. DARBOUZE				
LAB I.D. NO.		DATE COLLECTED		DATE RECEIVED		DATE OF REPORT		AGE	SEX
104994572		07/02/2007		07/03/2007 09:45		7/3/2007 12:30		40 Y	M

Test Description	Result	Abnormal	Reference Range
------------------	--------	----------	-----------------

-----* MISCELLANEOUS *-----

PSA 3rd.GEN.	0.731		<4.0 ng/mL
--------------	-------	--	------------

The PSA assay should not be the only test used for diagnostic purposes. Additional evaluation using DRE, ultrasound, TUR or similar procedures may be used for this purpose. Predictions of disease recurrence should not be based solely upon values obtained from serial PSA values obtained on the patient.
PSA method: Roche Diagnostics/electrochemiluminescence Immunoassay.

Final Report

Page: 3

James Weisberger
James Weisberger, M.D.
Laboratory Director

[Signature] 7/3/07



PRISON
HEALTH
SERVICES
INCORPORATED

DEPARTMENT OF CORRECTIONS

DATE: 6/28/07
11:00 am

URINALYSIS

LEUKOCYTES Neg

NITRITE Neg

UROBILINOGEN Normal

PROTEIN Neg

pH 5

BLOOD Neg

SPEC. GRAVITY 1.015

KETONE Neg

GLUCOSE Neg

HCG _____

(Add: Final Labs Here)

INMATE NAME (LAST, FIRST, MIDDLE) <u>Thomas Barry</u>	DOC # <u>178628</u>	DOB <u>11/20/66</u>	RACE/SEX <u>W/M</u>	FAC. <u>PHS test</u>
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LABORATORY REPORTS

PHS-MD-70012

PHS077

ACCESSION NO. 131/178628	NAME <i>B. Garry</i> BAWY THOMAS	FACILITY Easterling
------------------------------------	---	-------------------------------

DATE COLLECTED 5/22/06	TIME COLLECTED 8:30 AM
----------------------------------	----------------------------------

DATE RECEIVED 5/26/06	TIME RECEIVED 8:30 AM
---------------------------------	---------------------------------

Test Name	Result	Out of Range	Reference Range
HIV ANTIBODY	NT		NEGATIVE (NEG)
RPR	NR		NON-REACTIVE (NR)
URINALYSIS			
PROTEIN	NT		NEGATIVE (NEG)
GLUCOSE	NT		NEGATIVE (NEG)
KETONES	NT		NEGATIVE (NEG)
BILIRUBIN	NT		NEGATIVE (NEG)
BLOOD	NT		< 5 RBC/MCL (NEG)
NITRITE	NT		NEGATIVE (NEG)
UROBILINOGEN	NT		< 1.0 MG/DL (NEG)
LEUK. ESTERASE	NT		NEGATIVE (NEG)

* NT = Not Tested

CLIA ID NO. 01D0706289

WAYNE D. MERCER, PHD
LABORATORY DIRECTOR

PHS078

Specimen #	Type	Primary Lt	Report Status
335-297-0131-0	0	MR	FINAL
Additional Information			
DOB: 11/20/66			
CD- 31622934646			
Client Name	Sex	Age (Yr/Mos)	
THOMAS, BARRY	M	038/00	
Client Address			
Date Collected	Date Entered	Date Reported	
11/29/04	11/30/04	12/01/04	3149

Clinical Information		12/01/04 07:11 ET
Physician ID	Patient ID	
0000000000	178628	
Account		
Easterling Corr. Facility		01488855
Prison Health Services		01
200 Wallace Dr.		01
Clio, AL 36017-0010		
334-397-4471 ALN		

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
			1/2 Avg. Risk	3.4 3.3	
			Avg. Risk	5.0 4.4	
			2X Avg. Risk	9.6 7.1	
			3X Avg. Risk	23.4 11.0	

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

thyroid					ME
TSH	2.371		uIU/mL	0.350 - 5.500	ME
Thyroxine (T4)	5.9		ug/dL	4.5 - 12.0	ME
T3 Uptake	37		%	24 - 39	ME
Free Thyroxine Index	2.2			1.2 - 4.9	ME
BC, Platelet Ct, and Diff					ME
White Blood Cell (WBC) Count	6.2		x10E3/uL	4.0 - 10.5	ME
Red Blood Cell (RBC) Count	5.23		x10E6/uL	4.10 - 5.60	ME
Hemoglobin	15.9		g/dL	12.5 - 17.0	ME
Hematocrit	46.8		%	36.0 - 50.0	ME
MCV	89		fL	80 - 98	ME
MCH	30.4		pg	27.0 - 34.0	ME
MCHC	34.0		g/dL	32.0 - 36.0	ME
RDW	13.4		%	11.7 - 15.0	ME
Platelets	181		x10E3/uL	140 - 415	ME
Neutrophils	51		%	40 - 74	ME
Lymphs	36		%	14 - 46	ME
Monocytes	9		%	4 - 13	ME
Eos	3		%	0 - 7	ME
Basos	1		%	0 - 3	ME
Neutrophils (Absolute)	3.2		x10E3/uL	1.8 - 7.8	ME
Lymphs (Absolute)	2.2		x10E3/uL	0.7 - 4.5	ME
Monocytes (Absolute)	0.6		x10E3/uL	0.1 - 1.0	ME
Eos (Absolute)	0.2		x10E3/uL	0.0 - 0.4	ME
Baso (Absolute)	0.1		x10E3/uL	0.0 - 0.2	ME

LAB: MB LabCorp Birmingham DIRECTOR: Arthur Kelly, MD
1801 First Avenue South Birmingham, AL 35233-0000

OR INQUIRIES, THE PHYSICIAN MAY CONTACT: BRANCH: 334-792-0902 LAB: 205-581-3500
LAST PAGE OF REPORT

Handwritten signature and date: 12/01/04

THOMAS, BARRY PATID: 178628 REPORT SPEC DATE: 11/30/2004 ©2004 Laboratory Corporation of America® Holdings All Rights Reserved

Specimen #	Type	Primary Lab	Report Status
334-397-2191-2	5	MS	FINOL
Additional Information			
DOB: 11/20/55			
CD- 51682954545			
Client Name	Sex	Age (Yr/Mos)	
THOMAS, BARRY	M	038/00	
Client Address			
Date Collected	Date Entered	Date Reported	
11/29/04	11/30/04	12/01/04	3149

Clinical Information	
Physician ID	Patient ID
DARBOUZE	178626
Account	
Easterling Corr. Facility	01488853
Prison Health Services	01
200 Wallace Dr.	01
Cllo	, AL 36017-0010
334-397-4471	GLN

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
MP12+LP+TP+TSH+6AC+CBC/D/Plt					
hemistries					ME
Glucose, Serum	93		mg/dL	65 - 99	ME
Uric Acid, Serum	5.8		mg/dL	2.4 - 8.2	ME
BUN	12		mg/dL	5 - 26	ME
Creatinine, Serum	0.7		mg/dL	0.5 - 1.5	ME
BUN/Creatinine Ratio	17			8 - 27	
Sodium, Serum	141		mmol/L	135 - 148	ME
Potassium, Serum	3.8		mmol/L	3.5 - 5.5	ME
Chloride, Serum	103		mmol/L	96 - 109	ME
Calcium, Serum	9.4		mg/dL	8.5 - 10.6	ME
Phosphorus, Serum	5.1	H	mg/dL	2.5 - 4.5	ME
Protein, Total, Serum	7.2		g/dL	6.0 - 8.5	ME
Albumin, Serum	4.4		g/dL	3.5 - 5.5	ME
Globulin, Total	2.8		g/dL	1.5 - 4.5	
A/G Ratio	1.6			1.1 - 2.5	
Bilirubin, Total	0.5		mg/dL	0.1 - 1.2	ME
Alkaline Phosphatase, Serum	72		IU/L	25 - 150	ME
LDH	161		IU/L	100 - 250	ME
AST (SGOT)	24		IU/L	0 - 40	ME
ALT (SGPT)	27		IU/L	0 - 40	ME
GGT	25		IU/L	0 - 65	ME
Iron, Serum	114		ug/dL	40 - 155	ME
lipids					ME
Cholesterol, Total	253	H	mg/dL	100 - 199	ME
Triglycerides	348	H	mg/dL	0 - 149	ME
HDL Cholesterol	47		mg/dL	40 - 59	ME
VLDL Cholesterol Calc	70	H	mg/dL	5 - 40	
LDL Cholesterol Calc	136	H	mg/dL	0 - 99	
Comment					ME

If initial LDL-cholesterol result is >100 mg/dL, assess for risk factors and refer to the ATP-III table below.

Risk Category	LDL Goal	LDL Level (mg/dL) at which to initiate Therapeutic Lifestyle Changes (TLC)	LDL Level (mg/dL) at which to consider Drug Therapy
---------------	----------	--	---

CHD	<100	>100	>or=130
2+ Risk Factors	<130	>or=130	>or=130
0-1 Risk Factors	<160	>or=160	>or=190
T. Chol/HDL Ratio	5.4	H ratio units	0.3 - 5.0
Estimated CHD Risk	1.1	H times avg.	0.0 - 1.0

T. Chol/HDL Ratio

Med. Wound

THOMAS, BARRY

PATID: 173626

REPORT

SPED DATE: 11/30/04

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Additional Information
 DOB: 11/20/66
 CD- 51619533784
 Patient Name: THOMAS, BARRY
 Sex: M Age (Yr/Mos): 037/10
 Date Collected: 10/05/04 Date Entered: 10/05/04 Date Reported: 10/06/04 2763

Clinical Information
 Physician ID: 178628
 Account: Easterling Corr. Facility 01498855
 Prison Health Services 01
 200 Wallace Dr. 01
 Cllo, AL 36017-0010
 334-397-4471 ALN

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
			1/2 Avg. Risk	3.4 3.3	
			Avg. Risk	5.0 4.4	
			2X Avg. Risk	9.6 7.1	
			3X Avg. Risk	23.4 11.0	

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of pre-mature CHD.

Thyroid					ME
TSH	2.837		uIU/mL	0.350 - 5.500	ME
Thyroxine (T4)	5.8		ug/dL	4.5 - 12.0	ME
T3 Uptake	35		%	24 - 39	ME
Free Thyroxine Index	2.0			1.2 - 4.9	ME
WBC, Platelet Ct, and Diff					ME
White Blood Cell (WBC) Count	6.1		x10E3/uL	4.0 - 10.5	ME
Red Blood Cell (RBC) Count	5.32		x10E6/uL	4.10 - 5.60	ME
Hemoglobin	16.3		g/dL	12.5 - 17.0	ME
Hematocrit	47.8		%	36.0 - 50.0	ME
MCV	90		fL	80 - 98	ME
MCH	30.6		pg	27.0 - 34.0	ME
MCHC	34.0		g/dL	32.0 - 36.0	ME
RDW	13.9		%	11.7 - 15.0	ME
Platelets	194		x10E3/uL	140 - 415	ME
Neutrophils	57		%	40 - 74	ME
Lymphs	31		%	14 - 46	ME
Monocytes	8		%	4 - 13	ME
Eos	3		%	0 - 7	ME
Basos	1		%	0 - 3	ME
Neutrophils (Absolute)	3.5		x10E3/uL	1.8 - 7.8	ME
Lymphs (Absolute)	1.9		x10E3/uL	0.7 - 4.5	ME
Monocytes (Absolute)	0.5		x10E3/uL	0.1 - 1.0	ME
Eos (Absolute)	0.2		x10E3/uL	0.0 - 0.4	ME
Baso (Absolute)	0.1		x10E3/uL	0.0 - 0.2	ME

Please note

The date and/or time of collection was not indicated on the requisition as required by state and federal law. The date of receipt of the specimen was used as the collection date if not supplied.

LAB: MB LabCorp Birmingham DIRECTOR: Arthur Kelly, MD
 1801 First Avenue South Birmingham, AL 35233-0000

THOMAS, BARRY

PATID: 178628

REPORT

DATE: 10/05/2004

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AL

DEPARTMENT OF CORRECTIONS

RADIOLOGY SERVICES REQUEST AND REPORT

INSTITUTION: EasterlingName: THOMAS - BARRYState ID No.: 178628DOB: 11-20-66Race: W Sex: M

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP

Date of request

Time of request

Routine

Priority

Transportation or special needs

HISTORY/DIAGNOSIS:

6-11-07 Officer Gordon
 TI 752
 TO 1000
 NO SHOW

X-RAY REQUEST

ABDOMEN/KUB	FINGERS	NAVICULAR VIEW	SOFT TISSUE STUDIES
ACROMIO-CLAVICULAR JOINTS (W/O WEIGHT)	FOOT	ORBITS	STERNUM
ANKLE	HAND	OS CALCEI (HEEL)	TEMPORO-MANDIBULAR JOINTS
CERVICAL SPINE	HIP	PELVIS	THORACIC SPINE
CHEST PA / LATERAL	HUMERUS	RADIUS/ULNA	TIBIA/FIBULA
COCCYX	KNEE	RIBS	TOES
CONE DOWN SELLA TURCICA	LUMBAR SPINE	SACRO-ILIAC JOINTS	WREST
ELBOW	MANDIBLE	SCAPULA	ZYGOMA
FACIAL BONES	MAXILLA	SHOULDER	ZYGOMATIC ARCH
FEMUR	NASAL BONES	SKULL	

Thomas

REPORT

LUMBAR SPINE: The vertebrae are well aligned and show no evidence of any fracture or any destructive bone disease.

IMPRESSION: NORMAL STUDY.

D & T: 06-13-07 Maurice H. Rowell/rr Board Certified Radiologist (Signature on file)

X-RAY TECHNOLOGIST'S NAME (PRINT)

X-RAY TECHNOLOGIST'S SIGNATURE

DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT)

RADIOLOGIST'S SIGNATURE

DATE, TIME

(WED) JUN 13 2007 12:50/ST. 12:08/NO. 6312281831 P 2

FROM CAHARA IMAGING

PHS082

AL

DEPARTMENT OF CORRECTIONS

RADIOLOGY SERVICES REQUEST AND REPORT

INSTITUTION: EasklinName: Thomas BawState ID No: 178628DOB: 11-20-66Race: W/mSex:

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP <u>Dr. Danabere</u>	Date of request <u>11-28-05</u>	Time of request	Routine	Priority	Transportation or special needs
HISTORY/DIAGNOSIS:					

X-RAY REQUEST					
ABDOMEN/KUB		FINGERS		NAVICULAR VIEW	
ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)		FOOT		ORBITS	
ANKLE		HAND		OS CALCEI (HEEL)	
CERVICAL SPINE		HIP		PELVIS	
CHEST PA / LATERAL		HUMERUS		RADIUS/ULNA	
COCCYX		KNEE		RIBS	
CONE DOWN SELLA TURCICA	X	LUMBAR SPINE		SACRO-ILIAC JOINTS	
ELBOW		MANDIBLE		SCAPULA	
FACIAL BONES		MAXILLA		SHOULDER	
FEMUR		NASAL BONES		SKULL	
				SOFT TISSUE STUDIES	
				STERNUM	
				TEMPO-MANDIBULAR JOINTS	
				THORACIC SPINE	
				TIBIA/FIBULA	
				TOES	
				WRIST	
				ZYGOMA	
				ZYGOMATIC ARCH	

REPORT

Thomas

LUMBAR SPINE: The vertebrae are well aligned and show no evidence of any fracture or any destructive bone disease.

IMPRESSION: NORMAL STUDY.

D & T: 11-28-05 Howard P. Schiele, M.D./rr Board Certified Radiologist (Signature on file) p

X-RAY TECHNOLOGIST'S NAME (PRINT)

X-RAY TECHNOLOGIST'S SIGNATURE

DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT)

RADIOLOGIST'S SIGNATURE

DATE SIGNED

BILLOWE WOLFE WOLF

PHS083

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: BARRY R. THOMAS Date of Request: 1-31-2001

ID #: 178628 Date of Birth: 11-20-66 Housing Location: KFD-71

Nature of problem or request: TOOTH FILLING HAS CHIPPED IN
A FRONT TOOTH.

I consent to be treated by health staff for the condition described.

Barry R. Thomas
SIGNATURE

**PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA**

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP _____ P _____ R _____ T _____

Assessment:

Plan:

RHC
of Feb. 23, 2001 At 1:00pm

Refer to: _____ PA/Physician _____ Mental Health ☒ Dental

Signature: M. Squire Title: RHC Date: 2-1-01 Time: 9:30 AM

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: Barry Thomas Date of Request: 11-29-98
ID #: 178628 Date of Birth: 11-20-66 Housing Location: K-71
Nature of problem or request: Filling came out of a front tooth.

I consent to be treated by health staff for the condition described.

Barry Thomas
SIGNATURE

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP _____ P _____ R _____ T _____

Assessment:

Plan:

Refer to: PA/Physician _____ Mental Health _____ Dental _____

Signature: E. Hardy Title: PA Date: 11/30/98 Time: 10:55am

CMS 7166 REV. 10/94

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: Barry R. Thomas Date of Request: 8-5-98
ID #: 178628 Date of Birth: 11-20-66 Housing Location: KCB-19
Nature of problem or request: Filling fell out of a front
tooth.

I consent to be treated by health staff for the condition described.

Barry R. Thomas
SIGNATURE

**PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA**

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP _____ P _____ R _____ T _____

Assessment:

Plan: RTC for OP

Refer to: _____ PA/Physician _____ Mental Health _____ Dental

Signature: E. Bowdy Title: DA Date: 8-6-98 Time: 9:25 Am

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: Barry R. Thomas Date of Request: Jan. 6, 1998

ID #: 178628 Date of Birth: 11-20-66 Housing Location: KCB-19

Nature of problem or request: Need teeth cleaned

I consent to be treated by health staff for the condition described.

Barry R. Thomas
SIGNATURE

**PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA**

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP _____ P _____ R _____ T _____

Assessment:

Plan:

RHC
px

Refer to: _____ PA/Physician _____ Mental Health _____ Dental

Signature: M Squire Title: RDT Date: 1-6-98 Time: _____

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: Barry R. Thomas Date of Request: 1-1-97

ID #: 178628 Date of Birth: 11-20-96 Housing Location: KCB-19

Nature of problem or request: I would like an appointment to
have my teeth cleaned. (I'll be at print shop dental call)
Thank you

I consent to be treated by health staff for the condition described.

Barry R. Thomas
SIGNATURE

**PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA**

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP _____ P _____ R _____ T _____

Assessment:

Plan:

RYC
PX

Refer to: _____ PA/Physician _____ Mental Health _____ Dental

Signature: M. Squire Title: RDH Date: 1-2-97 Time: _____



DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, BARRY THOMAS 178628
(Print Name) (Doc#)

acknowledge receipt of the following medical equipment or appliance:

- () Splint
() Eyeglasses
() Dentures
() Prothesis describe _____
() Wheelchair
() Cane
(X) Crutches X 1 week START 7-2-07
() Other describe _____

Return 7/9/07

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Barry Thomas 178628 7/2/07
(Inmate) (Date)

[Signature] 7-2-07
(Witness) (Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
THOMAS - BARRY	178628	11-20-66	W/M	EAR.

PHS-MD-70005

(White - Medical File, Yellow - Security Property Officer)



PRISON
HEALTH
SERVICES
INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 7-2-07

To: Doc

From: HCU

Inmate Name: BARRY THOMAS ID#: 178628

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

CPUtches X 1 week

START 7-2-07 STOP 7-9-07

Date: 7-2-07 MD Signature: DR DA Long / B. Chaudh Time: 12¹⁰/17

60418

Barry Thomas 178628



RELEASE OF RESPONSIBILITY

Inmate's Name: Barry ThomasDate of Birth: 11/20/66 Social Security No.: _____Date: 6/22/07 Time: 7:15 A.M.
P.M.This is to certify that I, Barry Thomas, currently in
(Print Inmate's Name)custody at the Easterling, am refusing to
(Print Facility's Name)accept the following treatment/recommendations: refuses MD appt.
(Specify in Detail)
on 6/22/07

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Barry Thomas (Signature of Inmate)**

(Signature of Medical Person)
S. Bushupri

(Witness) (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.



E2-6A

RELEASE OF RESPONSIBILITY

Inmate's Name: Thomas, BarryDate of Birth: 11/20/66 Social Security No.: 178628Date: 6-14-07 Time: 9:00 P.M.This is to certify that I, Thomas, Barry, currently in
(Print Inmate's Name)custody at the ECF, am refusing to
(Print Facility's Name)accept the following treatment/recommendations: sick call no show
(Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Refusal to sign
(Signature of Inmate)**

[Signature]
(Signature of Medical Person)

[Signature]
(Witness)

[Signature]
(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.



DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, BARRY R. THOMAS 178628
 (Print Name) (Doc#)

acknowledge receipt of the following medical equipment or appliance:

- () Splint
 () Eyeglasses
 () Dentures
 () Prosthesis describe _____
 () Wheelchair
 () Cane
 (X) Crutches
 () Other describe 1 Crutch + 1 walker

*Collected
6/18/07
DS*

6/8/07 - 6/15/07

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Barry Thomas
 (Inmate)

6/15/07
 (Date)

[Signature]
 (Witness)

6/15/07
 (Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
THOMAS BARRY	178628	11/20/66	W/M	Elstark



SPECIAL NEEDS COMMUNICATION FORM

Date: 6-8-07

To: Doc

From: Hcu

Inmate Name: THOMAS - BARRY ID#: 178628

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

CRUTCH X 1 WEEK
START 6-8-07 STOP 6-15-07

Date: 6-8-07 MD Signature: Dr Day / Doc Time: 1³⁰

60418

X Barry Thomas

PRISON
HEALTH
SERVICES
INCORPORATED

EMERGENCY

ADMISSION DATE 6/18/07 4:50		TIME AM PM	ORIGINATING FACILITY ECF		<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input checked="" type="checkbox"/> OUTPATIENT	
ALLERGIES NKDA			CONDITION ON ADMISSION <input checked="" type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA			
VITAL SIGNS: TEMP 97.5		ORAL RECTAL	RESP. 20	PULSE 76	B/P 122/78	RECHECK IF SYSTOLIC <100> 50
NATURE OF INJURY OR ILLNESS 5- "My lower back pain is getting worse. I can hobble enough in the afternoon to make it to pull call & chow, but it's impossible to do it in the AM anymore" - States did not fall - just unable to walk. O- 1/M to HCU via stretcher, SKIN w/d, resp ext'd & unlabored. No pain @ back down mid posterior @ leg down to ankle. Muscle tight in @ back. Placed in infirmary via WC - 1/M being to R in WC. States is unable to sit upright for more than a few minutes. A - alt comfort			ABRASION /// CONTUSION # BURN xx xx FRACTURE Z LACERATION / Z SUTURES PROFILE RIGHT OR LEFT RIGHT OR LEFT			
ORDERS / MEDICATIONS / IV FLUIDS P-Give a.m. meds - hold in infirmary until seen by MD. This a.m.					TIME	BY
DIAGNOSIS						
INSTRUCTIONS TO PATIENT						
DISCHARGE DATE / /		TIME AM PM	RELEASE / TRANSFERRED TO <input type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE <input type="checkbox"/>		CONDITION ON DISCHARGE <input type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE J. Smith		DATE 6/18/07	PHYSICIAN'S SIGNATURE A		DATE 6/18/07	
INMATE NAME (LAST, FIRST, MIDDLE) THOMAS, BARRY			DOB# 178628	DOB 11-20-66	R/S W/M	FAC. ECF



SPECIAL NEEDS COMMUNICATION FORM

Date: 6-5-07

To: Doc

From: PHB

Inmate Name: Thomas Bawly ID#: 178628

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Bottom Bank Profile X 2wks
6-5-07 → 6-19-07

Date: 6-5-07 MD Signature: W Dr. Dabore/jm Time: 12:35 pm

Bawly Thomas 178628

60418



SPECIAL NEEDS COMMUNICATION FORM

Date: 5-30-07

To: DOC - Easerling

From: HCU

Inmate Name: Thomas, Barry ID#: 178628

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Continue Bottom Bunk profile until seen by MD on 6-5-07.

Date: 5-30-07 MD Signature: W.D. Dalboush / Culamillo, RN Time: 5:50 pm

60418

Barry Thomas



RELEASE OF RESPONSIBILITY

Inmate's Name: BARRY THOMAS

Date of Birth: 11-20-66 Social Security No.: ATIS # 178628

Date: 5-29-07 Time: 800 AM.
PM.

This is to certify that I, Barry Thomas, currently in
(Print Inmate's Name)

custody at the Easterling, am refusing to
(Print Facility's Name)

accept the following treatment/recommendations: SICK call 5-29-07
(Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Barry Thomas 178628
(Signature of Inmate)**

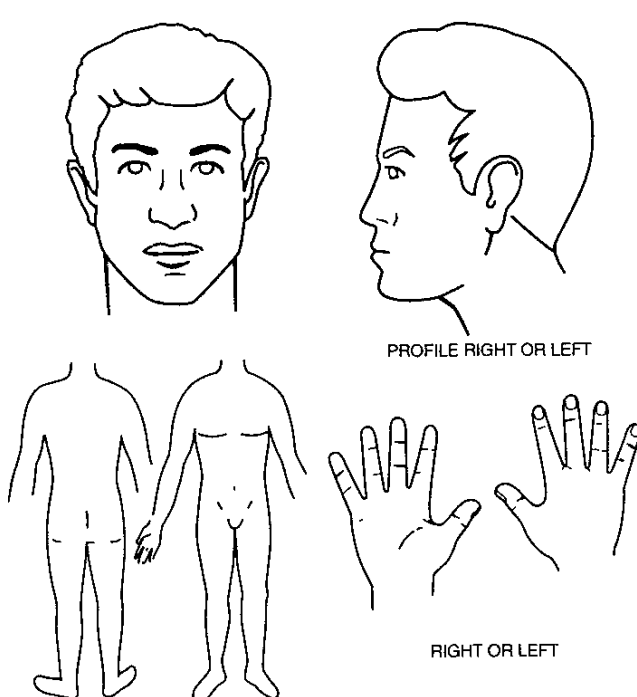
W. Amelak
(Signature of Medical Person)

James M. Hill COI
(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

EMERGENCY

ADMISSION DATE 5/28/07		TIME 8:45 <small>AM PM</small>	ORIGINATING FACILITY East	<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input checked="" type="checkbox"/> OUTPATIENT	
ALLERGIES NKA			CONDITION ON ADMISSION <input checked="" type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA		
VITAL SIGNS: TEMP 97 <small>ORAL RECTAL</small>		RESP. 16	PULSE 80	B/P 124/80	RECHECK IF SYSTOLIC <100> 50 1
NATURE OF INJURY OR ILLNESS S. I have Pressure on my nerve. I can't put any pressure on my leg. O- Brought to Human Services. A- took 3. Legs are all up. Able to overcome gravity. I am all up. Able to flex & ext legs & difficult. No pain to Q lip area. Broken area on bruises noted site.			ABRASION /// CONTUSION # BURN <small>xx xx</small> FRACTURE <small>Z Z</small> LACERATION / SUTURES		
					
PHYSICAL EXAMINATION A alt-in comfort P- Ambulate & assist to Infirmary for observation 11:30 Ambulating in Infirmary & assist. Gait steady. States I feel better the pain goes & goes. 12:00 Released to pop. Encouraged compliant & med tx.			ORDERS / MEDICATIONS / IV FLUIDS TIME BY		
DIAGNOSIS					
INSTRUCTIONS TO PATIENT					
DISCHARGE DATE 5/28/07		TIME 12:15 <small>AM PM</small>	RELEASE / TRANSFERRED TO DOC	CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE [Signature]		DATE	PHYSICIAN'S SIGNATURE [Signature]	CONSULTATION	
INMATE NAME (LAST, FIRST, MIDDLE) Thomas Barry			DOC# 178648	DOB 11-20-66	R/S W/M
			FAC. EC		



SPECIAL NEEDS COMMUNICATION FORM

Date: 5-15-07To: DocFrom: HCUInmate Name: BARRY THOMAS ID#: 178628

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Bottom Back Profile X 2 weeksSTART 5-15-07 STOP 5-30-07Barry R. Thomas 178628Date: 5-15-07 MD Signature: DK Dyer / D. Dyer Time: 11:52 AM

60418

**RELEASE OF RESPONSIBILITY**Inmate's Name: Barry ThomasDate of Birth: 11/20/66 Social Security No.: # 178628Date: 5/3/07 Time: 1015 AM.
P.M.This is to certify that I, Barry Thomas, currently in
(Print Inmate's Name)custody at the ECF, am refusing to
(Print Facility's Name)accept the following treatment/recommendations: no show S/K
(Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

(Signature of Inmate)**

(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

HEALTH CARE UNIT
PATIENT INFORMATION SLIPVentress

INSTITUTION

Barry Thomas 178628 W
NAME NUMBER R/S

Lay-in for _____ days from _____ to _____
(date) due to _____
(date)

Instructions:

Return to the HCU
10-15-02 @ 8³⁰am to
See Ms King

Failure to follow the directions above may result in a disciplinary.

Date Issued

10-15-02

Signature

Dee PBarry Thomas

F-53

HEALTH CARE UNIT
PATIENT INFORMATION SLIPVentress

INSTITUTION

Thomas, Barry 178628
NAME NUMBER R/S

Lay-in for _____ days from _____ to _____
(date) due to _____
(date)

Instructions:

To HCU on Wednesday
October 30, 2002 at 1³⁰pm
for follow up with Dr. Darby.

Failure to follow the directions above may result in a disciplinary.

Date Issued

10-24-02

Signature

Barry Thomas

F-53

Case 2:07-cv-00630-MEF-WC Document 20-4 Filed 08/22/2007 Page 104 of 134
HEALTH CARE UNIT
PATIENT INFORMATION SLIP

VCF

INSTITUTION

Thomas, Barry 178628 W/M
NAME NUMBER R/S

Lay-in for _____ days from _____ to _____
(date) due to _____
(date)

Instructions: Return to HCU on Monday
7/22/02 at 1:30pm to
see MID

Failure to follow the directions above may result in a disciplinary.

7/19/02
Date Issued

Signature

Barry L. Thomas

F-53

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

VCF

INSTITUTION

Thomas Barry 178628 W/M
NAME NUMBER R/S

Lay-in for _____ days from _____ to _____
(date) due to _____
(date)

Instructions: Slide profile for 1 Done
Week 7/23/02 to end 7/30/02

Failure to follow the directions above may result in a disciplinary.

7/22/02
Date Issued

Signature

F-53

Barry L. Thomas

PHS103

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

VCF

INSTITUTION

Thomas Barry

NAME

178628 w/m

NUMBER

R/S

Lay-in for _____ days from _____ to _____

(date)

due to _____

(date)

Instructions:

Return to HCU

on Fri. 7/19/02

at 130pm for MD

appt.

Failure to follow the directions above may result in a disciplinary.

Date Issued

7/17/02

Signature

D. Baugh

Barry Thomas

F-53

N610

ALABAMA DEPARTMENT OF CORRECTIONS

RECEIVING SCREENING FORM

Inmate's Name: Thomas, Barry R Date: 5-13-02 Time: 9:15 AM
 DOB: 11-20-66 Officer: A. Woods Institution: VCF

Receiving Officer's Visual OpinionYes ☒ No ☐

1. Is the inmate conscious? ☒ Yes ☐ No
2. Does the inmate have any obvious pain or bleeding/other symptoms suggesting the need for emergency services? ☐ Yes ☐ No
3. Are there any visible signs of trauma or illness requiring immediate emergency treatment or doctor's care? ☐ Yes ☒ No
4. Any obvious fever, swollen lymph nodes, jaundice, or other evidence of infection which might spread through the institution? ☐ Yes ☒ No
5. Is the skin in poor condition or show signs of vermin or rashes? ☐ Yes ☒ No
6. Does the inmate appear to be under the influence of alcohol or drugs? ☐ Yes ☒ No
7. Are there any visible signs of alcohol or drug withdrawal? (extreme perspiration, shakes, nausea, pinpoint pupils, etc.) ☐ Yes ☒ No
8. Is the inmate making any verbal threats to staff or other inmates? ☐ Yes ☒ No
9. Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available? ☐ Yes ☒ No
10. Does the inmate have any obvious physical handicaps? ☐ Yes ☒ No

If the answer is YES to any questions from 2-10 above, specify WHY in section below.

11. Are you presently taking medication for diabetes, heart disease, seizure, arthritis, asthma, ulcers, high blood pressure or psychiatric disorder? ☐ Yes ☒ No
12. Are you on any special diet prescribed by a physician? (if YES, what type?) ☐ Yes ☒ No
13. Do you have a history of venereal disease or abnormal discharge? ☐ Yes ☒ No
14. Have you recently been hospitalized or recently seen a medical or psychiatric doctor for any illness? ☐ Yes ☒ No
15. Have you ever attempted suicide? 3 times ☐ Yes ☒ No
 (If YES, When? 1984, 1989, 1994 How? Valium overdose, handgun)
16. Do you want to do any harm to yourself now? 3 overdose ☐ Yes ☒ No

All inmates have access to healthcare 24 hrs. a day, 7 days a week. Treatment for routine health services complaints is processed through nurse sick call. You must complete a sick call screening form for requested health care evaluation. Various doctor's clinics are held in the health unit Monday through Friday. If you are scheduled to be seen in a clinic you will be advised by facility daily newsletters routinely post notices of who is to report when and where for health care services. If you complete a sick-call form, please report to sick call the next business day, no later than 5:30am. Routine sick call will not be posted in the newsletter, but D.O.C. has a log of who has signed up for sick call. If you request health services and do not show for evaluation you must sign a refusal of treatment form. If a health services appointment/clinic or treatment has been set for you and you do not show you will also have to sign a refusal of treatment for. This is to let us know you have decided you are okay and no longer need to see us. Nurses are in house twenty-four hours a day seven days a week for routine health services and programs. Nurses are also available for emergency care. Doctor's are on call twenty-four hours a day seven days a week. In-house medical staff reviews medical services requested over the weekend and on holidays. If your request is noted to be of a nature that will not wait until the next regularly scheduled evaluation (triage) time, you will be called to the health unit for further follow-up during this time period other wise your request will be held until the next regularly scheduled evaluation process. Medical emergencies such as those involving intense pain, potential life threatening situations or when delaying treatment might cause permanent damage are dealt with at any time. Advise the nearest correctional officer of an emergency so prompt access to health services is provided. Medications ordered for you by health services are to be picked up at the scheduled pill call/s established as the Doctor has ordered for you. If you fail to pick-up medications as expected you will be called for counseling. If you continue to fail to pick-up your medications you will be required to sign a refusal of treatment form. Remember that health services are a joint effort between the patient and the health care provider. We expect you to help us help you. Fee for services. You truly understand that no one would be denied access to health services because they are unable to pay the \$3.00 co-pay fee. You will be seen and services will be provided that are appropriate and deemed necessary. Health services staff does not collect co-pay fees for health services nor do monies collected go to the medical provider. A nurse visit or doctor visit charge of \$3.00 is the co-pay fee. If you do not have money in your PMOD account and you are assessed a charge you will have a negative balance in your until this is cleared. A negative balance will follow you from institution to institution upon transfer. When you seek health services you will be asked to sign the co-pay signature sheet. If it is deemed that you indeed do not owe for services your account will not be charged and if a false charge is made you will be refunded. Again we do have money and are eligible to be charged the co-pay fee this will occur. If the health unit initiates the request for you to be seen there is no charge. Educational in-services are routinely scheduled. Please attend and participate. Notice of in-services topics, dates and times will be published and posted in advance. Complaints against health care are attempted to be resolved as soon as possible and as reasonably as possible. You may obtain a complaint form from the same place you obtain sick call request slips and you may return these where you return your sick call request slips. If your complaint is not resolved when health services person speaks with you, you may file a grievance. This form will be given to you by the health person that has attempted to resolve the complaint. A complaint form must be initiated before a grievance form can be completed. Let your family and loved one's know health services will not disclose your medical care through conversations with them. If we are contacted you should know that we will review your health records but will have to let them know what you feel they should know about you. Understand, we will assure your family and loved one's you have health services available. We will also tell them that they must go through you or the Department of Corrections for release of information and that you must go through the appropriate procedures and access health services and also follow medical service recommendations. Be compliant with

The health services provided for you by your health providers. If you have had health services outside the prison system and we do not have these records you will need to sign release of records forms so we can obtain copies for placement in your institutional health record. A physical is begun on you upon your arrival into the prison system. You will be notified yearly thereafter when your next physical is scheduled. Mental health services dental services; medical services, chronic care clinics and many other health services are available. We wish you a healthy stay. If you need medical services we want you to understand how these services are obtained. Certain over the counter medications are available to you through canteen purchase. Medical service is not involved in canteen operations. We follow doctor's orders when dispensing medication-dose and time. If over the counter medication is given by health services it is through the order of a doctor. Population pill call at this institution are scheduled as listed below. If you have medication ordered report to the pill call your medication is to be dispensed at.

3:00 AM	3:00PM
9:00 AM	6:00PM

segregation lock-up pill call times are as listed below. Your medication will be issued to you on medication rounds.

3:00 AM	2:30PM
8:00 AM	

If you have a question request an answer.

Barry Thomas 4-16-02
INMATE SIGNATURE/ DATE

[Signature] 4/16
WITNESS SIGNATURE/DATE

137178628

N610

ALABAMA DEPARTMENT OF CORRECTIONS

RECEIVING SCREENING FORM

Inmate's Name: Thomas, Barry R Date: 3-8-02 Time: _____
 DOB: 11-20-66 Officer: _____ Institution: VCF

Receiving Officer's Visual Opinion

Yes No

- | | | |
|---|-------------------------------------|-------------------------------------|
| 1. Is the inmate conscious? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the inmate have any obvious pain or bleeding/other symptoms suggesting the need for emergency services? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Are there any visible signs of trauma or illness requiring immediate emergency treatment or doctor's care? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Any obvious fever, swollen lymph nodes, jaundice, or other evidence of infection which might spread through the institution? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Is the skin in poor condition or show signs of vermin or rashes? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Does the inmate appear to be under the influence of alcohol or drugs? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Are there any visible signs of alcohol or drug withdrawal? (extreme perspiration, shakes, nausea, pinpoint pupils, etc.) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Is the inmate making any verbal threats to staff or other inmates? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Does the inmate have any obvious physical handicaps? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

If the answer is YES to any questions from 2-10 above, specify WHY in section below.

- | | | |
|---|--------------------------|-------------------------------------|
| 11. Are you presently taking medication for diabetes, heart disease, seizure, arthritis, asthma, ulcers, high blood pressure or psychiatric disorder? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 12. Are you on any special diet prescribed by a physician? (if YES, what type?) | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 13. Do you have a history of venereal disease or abnormal discharge? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 14. Have you recently been hospitalized or recently seen a medical or psychiatric doctor for any illness? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 15. Have you ever attempted suicide? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| (If YES, When? _____ How? _____) | | |
| 16. Do you want to do any harm to yourself now? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

	Yes	No	No Response
17. Do you want to talk to a mental health counselor?	_____	<input checked="" type="checkbox"/>	_____
18. Are you allergic to any medication?	_____	<input checked="" type="checkbox"/>	_____
19. Have you recently fainted or had a head injury?	_____	<input checked="" type="checkbox"/>	_____
20. Do you have epilepsy?	_____	<input checked="" type="checkbox"/>	_____
21. Do you have a history of tuberculosis?	_____	<input checked="" type="checkbox"/>	_____
22. Do you have diabetes?	_____	<input checked="" type="checkbox"/>	_____
23. Do you have hepatitis?	_____	<input checked="" type="checkbox"/>	_____
24. Do you have a painful dental problem?	_____	<input checked="" type="checkbox"/>	_____
25. Do you have any medical problem we should know about?	_____	<input checked="" type="checkbox"/>	_____
26. Do you have a past alcohol or drug history?	_____	<input checked="" type="checkbox"/>	_____
What type? <u>alcohol</u> How much use? <u>light</u>			
For how long? <u>1 yr.</u> Last time used? <u>1993</u>			

Comments: (Unusual behavior, etc.)

For the Officer:

27. Was the new inmate briefed on sick/dental call procedures? yes
28. This inmate was: a. Released for normal processing ✓
- b. Referred to appropriate health care unit ✓
- c. Immediately sent to health care unit _____

Officer's Signature

Note: This form is completed on inter and intra system transfers at receiving and will be filed in the inmates medical jacket to comply with ACA Standards 2-4289, 2-4290 and AMA Standard 140.

Inmate's Signature



SPECIAL NEEDS COMMUNICATION FORM

Date: 12/9/05

To: DOC

From: PHS

Inmate Name: Thomas Barry ID#: 178628

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

No Prolong Standing + 2 weeks
12/9/05 - 12/23/05

Date: 12/9/05 MD Signature: Wanda Darby Time: 1:30 pm

X Barry T. Thomas 178628

60418



SPECIAL NEEDS COMMUNICATION FORM

Date: 11-18-05

To: Doc

From: PHS

Inmate Name: Thomas Barry ID#: 178628

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

NO Prolonged Standing Profile X 2
Wks - 11-18-05 → 12-2-05

Date: 11-18-05 MD Signature: VO Dr. Dabore / PH Time: 9⁰⁰ AM

60418

Barry R. Thomas

PRISON HEALTH SERVICES
Alabama Department of Corrections
KOP Medication Protocol

The KOP program will allow specific inmates to keep certain kinds of medications on their possession. If they are caught selling, trading, or not taking the medication correctly, they will be removed from the list and face possible disciplinary actions. The KOP medications will include formulary medications.

1. The inmate will have in his possession the medication in blister pack. The inmate should take the medication as directed on the package sticker.
2. The inmate is to bring the package to the infirmary when he gets down to the reorder row of pills so the nursing staff can pull the sticker off the card and reorder. If the inmate waits until they have finished the last row of pills before coming to the nurse, they are likely to run out before their order comes in. The card will be checked at this time against the MAR to determine if the number of pills remaining is accurate (not too many left, not too few). This will be noted by looking at the date the card was given. Each inmate is responsible for keeping their medication in a secure area. We will not be responsible for stolen medications.
3. When the inmate receives their card of medication, usually #30 tabs per card, they should pop them out in numerical order, i.e. #30, #29, etc.
4. In order to be eligible for KOP, the inmate must have a good history of compliance and voice understanding of how this system works. They will not be eligible if their medication is insulin or a psychotropic medication, or has been known to be non-complaint in the past. The inmate will be required to come to the infirmary and sign a KOP agreement that we have formulated. At this time the staff will explain the procedure to the inmate and document that the information was explained and the individual can again sign that the program has been explained in its entirety.
5. Once we have established the program, other will be free to request to be placed on KOP. If research finds that he will qualify, we will repeat the above with this individual.
6. We will not place just anyone on KOP. The individual must have past history evaluated first. This program will not include out-patient or inpatient mental health inmates.
7. Inmates may be requested to present for a medication check at any time to see that the correct number of pills are accounted for. The Medical Staff will be doing random checks for compliance.
8. The inmate holds harmless PHS and its healthcare providers for incidents that may result from the inmate taking medication improperly, exchanging the medicine with other inmates, and consuming drugs/medication provided by other individuals that result in drug interactions.

Inmate Signature: *Barry Thomas* AIS#: *178620*
 Nurse Signature: *[Signature]* Date: _____



Release of Responsibility

BARRY R. THOMAS
Name of Inmate

4-25-03
Date

178625 11-20-66
Inmate ID Number/Date of Birth

I hereby refuse to accept the following treatment / recommendations:

MD appt.

I acknowledge that I have been fully informed of and understand the above treatment(s) or recommendation(s) and the risk(s) involved in refusing. I hereby release and agree to hold harmless NaphCare, Inc., its employees and agents from all responsibility and ill effect which may result from this action.

Barry R. Thomas
Inmate Signature

SBush
Witness

4/25/03 11A
Date / Time

The aforementioned inmate has refused the listed medical treatment(s)/recommendation(s) and has refused to sign this form.

Witness

Date / Time

Witness

Release of Responsibility

NC025

PHS113



Release of Responsibility

Thomas Barry
Name of Inmate

4/11/03
Date

128628
Inmate ID Number/Date of Birth

I hereby refuse to accept the following treatment / recommendations:

Sick call screening

I acknowledge that I have been fully informed of and understand the above treatment(s) or recommendation(s) and the risk(s) involved in refusing. I hereby release and agree to hold harmless NaphCare, Inc., its employees and agents from all responsibility and ill effect which may result from this action.

Thomas Barry
Inmate Signature

SBushum
Witness

4-11-03
Date / Time

The aforementioned inmate has refused the listed medical treatment(s)/recommendation(s) and has refused to sign this form.

Witness

Date / Time

Witness

Release of Responsibility

NC025

PHS114

HEALTH STATUS

Transferring
 Facility: Ventures
 Date: 4-3-03
 Time: 13 10
 Allergies: NKA
 Food Handler Approved Y/N

Name: Thomas, Barry
 AIS: 178628
 Age: _____ Date of Birth: 11-20-66
 Race: w Sex: m

Current Acute Conditions/Problems: _____
 Chronic Conditions/ Problems: Co

Current Medications- Name, Dosage, Frequency, Duration:
 Acute short term medications _____

Chronic Long Term Medications _____

Chronic Psychotropic Medications _____

Current Treatments: _____
 Follow up care Needed _____

Last PPD 7-28-02 Results OK mms Last Physical 7/30/02

Chronic Clinics _____

Specialty Referrals _____

Significant Medical History constipation, migraine HA

Physical Disabilities/Limitations _____

Assistive Devices/Prosthetics _____ Glasses _____ Contacts _____

Mental Health History/Concerns _____

Substance abuse Y/N _____ Alcohol Y/N Drugs Y/N
 Hx Suicide Attempt Date 1/1
 Hx Psychotropic Medication _____
 Previous Psychiatric Hospitalizations _____

Signature/Title/Date
Mcnefield f 4-3-03

Transfer Reception Screening

Date: 4/4/03 Time: 12:30 am pm

S: Current complaint N/A

Current medications/Treatments

N/A

O Physical Appearance/Behavior Wt 168 lbs

WNL

Deformities: Acute/Chronic N/A

188 P/B R 18 B/P 110/80

A well maintained white male 5 current medical c/p

P Disposition (Instructions: Check or circle as appropriate)

✓ Routine sick call instructions given

✓ Emergency referral

✓ HIV/TB Instructions given

✓ Physician referral

Urgent / Routine ✓

✓ Medication Evaluation

✓ Work/Program Limitation

✓ Special Housing

✓ Specialty Referrals

✓ Chronic Clinics

✓ Mental Health

✓ OTHER

✓ Infirmary Placement

Receiving Facility:

East

Signature/ Title:

Bracewell LPV

NC 071

Excerpts to be added to the discharge instructions

EASTERLING CORRECTIONAL FACILITY PROCEDURE FOR ACCESS TO HEALTH CARE

Treatment for routine medical complaints and mental health complaints are processed through nurse screening seven days a week. Inmates must complete a sick-call screening form and turn this form into medical services for processing. You may obtain screening forms from any dorm cube or shift commander's office. you need to place the screening form in the locked box located at the dining hall. All health service requests are subject to a \$3.00 co-pay being deducted from your PMOD account, depending on the nature of your request. Forms for segregation inmates will be collected by nursing personnel on 4:00am medication rounds. Doctor's clinic is held Monday through Friday excluding holidays or an unexpected emergency.

Inmates on sick-call screening must report for screening or sign a refusal of treatment form declining care. Screening for population is held on 1st shift at approximately 7:00am. Screening for segregation is held during the morning pill call rounds. Sick-call screening is held Sunday through Friday.

Pill call times for this institution are as follows:

POPULATION	DIABETIC	SEGREGATION
4:00am	3:00am	4:00am
9:00am	9:00am	10:00am
5:00pm	3:00pm	5:00pm

Medical request on weekends and holidays are reviewed. Any request for medical attention that cannot wait until the next sick-call clinic will be processed at that time. All other request will be held until regular Sunday through Friday sick call. Medical emergencies, such as those involving intense pain, potential life-threatening situations, or when delaying treatment might cause permanent damage are dealt with at any time. Advise the nearest Correctional Officer of an emergency, so prompt access to health care is provided.

You are required to sign up for Dental sick call using the same procedure as medical sick call. Population and Segregation Dental Screenings are held weekly on Monday evenings at 1:00pm in the Health Care Unit. Follow-up care, if needed, is scheduled at this time. Emergency dental service is provided 24 hours a day with a dentist on call. Those not meeting scheduled appointments must sign a refusal of treatment form.

Your medical care is important. This is a joint effort between you and the Health Care Staff. Prescribed medications are to be picked up at pill-call, appointments kept, and education in services attended.

Comfort medications, such as cold medicine, headache medicine ect. are available in the canteen.

We ask that medical complaints against the Health Care Unit try and be resolved face to face. If concerns cannot be resolved verbally, a written complaint may be filed. You may get this form in the Health Care Unit. You must complete this form listing specifically the reason for dissatisfaction, steps you have taken and the action requested to resolve the problem. Return this form to the Health Care Unit.

<u>Burt L. Thomas</u> Inmate Signature	<u>178625</u> AIS#	<u>4-4-03</u> Date
<u>B. Phares</u> Witness	<u>4/4/03</u> Date	<u>1235</u> Time

N610

ALABAMA DEPARTMENT OF CORRECTIONS

RECEIVING SCREENING FORM

B/182002
 Inmate's Name: BARRY THOMAS Date: 6-16-95 Time: 10:24am
 DOB: 3-22-75 Officer: BROWN Institution: B.C.C.F.

Booking Officer's Visual Opinion

Yes No

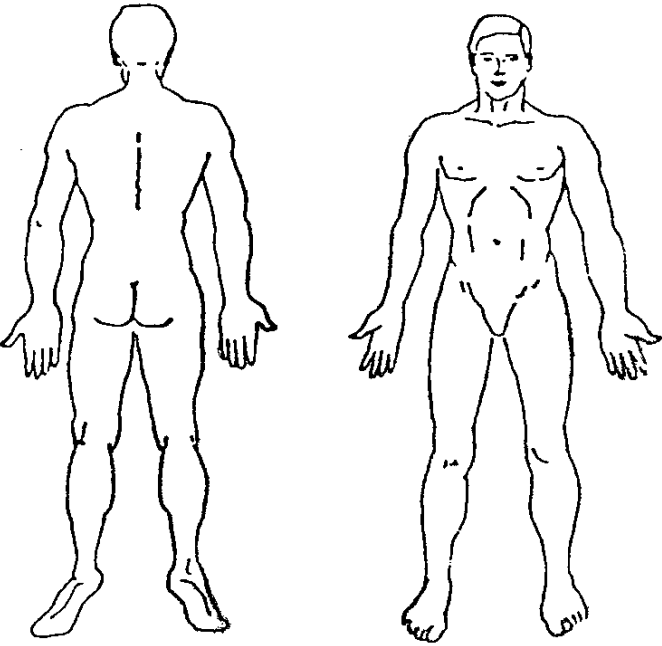
- | | | |
|---|-----------|-----------|
| 1. Is the inmate conscious? | <u>✓</u> | <u> </u> |
| 2. Does the inmate have any obvious pain or bleeding/other symptoms suggesting the need for emergency services? | <u> </u> | <u> </u> |
| 3. Are there any visible signs of trauma or illness requiring immediate emergency treatment or doctor's care? | <u> </u> | <u> </u> |
| 4. Any obvious fever, swollen lymph nodes, jaundice, or other evidence of infection which might spread through the institution? | <u> </u> | <u> </u> |
| 5. Is the skin in poor condition or show signs of vermin or rashes? | <u> </u> | <u> </u> |
| 6. Does the inmate appear to be under the influence of alcohol or drugs? | <u> </u> | <u> </u> |
| 7. Are there any visible signs of alcohol or drug withdrawal? (extreme perspiration, shakes, nausea, pinpoint pupils, etc.) | <u> </u> | <u> </u> |
| 8. Is the inmate making any verbal threats to staff or other inmates? | <u> </u> | <u> </u> |
| 9. Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available? | <u> </u> | <u> </u> |
| 10. Does the inmate have any obvious physical handicaps? | <u> </u> | <u> </u> |

If the answer is YES to any questions from 2-10 above, specify WHY in section below.

- | | | |
|---|-----------|-----------|
| 11. Are you presently taking medication for diabetes, heart disease, seizure, arthritis, asthma, ulcers, high blood pressure or psychiatric disorder? | <u> </u> | <u> </u> |
| 12. Are you on any special diet prescribed by a physician? (if YES, what type?) | <u> </u> | <u> </u> |
| 13. Do you have a history of venereal disease or abnormal discharge? | <u> </u> | <u> </u> |
| 14. Have you recently been hospitalized or recently seen a medical or psychiatric doctor for any illness? | <u> </u> | <u> </u> |
| 15. Have you ever attempted suicide? | <u> </u> | <u> </u> |
| (If YES, When? <u> </u> How? <u> </u>) | | |
| 6. Do you want to do any harm to yourself now? | <u> </u> | <u> </u> |

DEPARTMENT OF CORRECTIONS

EMERGENCY/ (OTHER) TREATMENT RECORD

DATE <u>10-29-94</u>		TIME <u>11:25</u> AM		FACILITY <u>KCF</u>		<input type="checkbox"/> EMERGENCY					
		<input type="checkbox"/> SIR <input type="checkbox"/> PDL <input type="checkbox"/> ESCAPEE <input type="checkbox"/>				<input checked="" type="checkbox"/> OTHER					
ALLERGIES <u>NKA</u>				CONDITION ON ADMISSION <input checked="" type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA							
VITAL SIGNS: TEMP _____		ORAL RECTAL _____		RESP. _____		PULSE _____ B/P <u>1</u>					
						RECHECK IF SYSTOLIC _____ <100> 50					
NATURE OF INJURY OR ILLNESS <u>S - LEANING back in chair</u> <u>fell backward & hit his</u> <u>head. Out for 1 second</u> <u>Headache</u>				ABRASION///		CONTUSION #					
				BURN ^{xx} / _{xx}		FRACTURE ^Z / _Z					
				LACERATION/		SUTURES					
PHYSICAL EXAMINATION <u>0 - No contusion or hematoma</u> <u>Noted</u>											
ORDERS, MEDICATION, etc. <u>P - Tylenol</u>											
DIAGNOSIS											
INSTRUCTIONS TO PATIENT <u>Den for sick call if needed</u>											
RELEASE/TRANSFER DATE		TIME		RELEASE/TRANSFERRED TO		DOC					
<u>10-02-94</u>		<u>AM</u>		<u>LL</u>		<input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR					
						<input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL					
NURSE'S SIGNATURE		DATE		PHYSICIAN'S SIGNATURE		DATE					
<u>C. Chalkley</u>		<u>10-29-94</u>		<u>[Signature]</u>							
PATIENT'S NAME (LAST, FIRST, MIDDLE)				AGE		DATE OF BIRTH					
<u>Thomas, Barry</u>				<u>27</u>		<u>11/20/66</u>					
				R/S		AIS #					
				<u>WM</u>		<u>178638</u>					

C N610
/87

ALABAMA DEPARTMENT OF CORRECTIONS

RECEIVING SCREENING FORM

INMATES NAME: THOMAS, BARRY DATE: 10/3/94 TIME: 10:30 am
 DOB: 11-20-66 OFFICER: Ben Brown INSTITUTION: BCCF

BOOKING OFFICERS VISUAL OPINION

Yes No

Yes

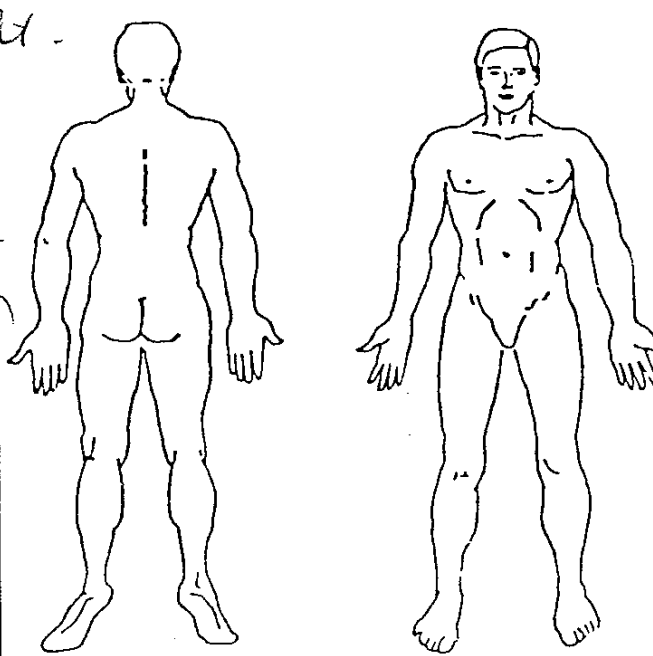
1. Is the Inmate Conscious ? Yes —
2. Does the inmate have any obvious pain or bleeding/other symptoms suggesting the need for emergency services ? — —
3. Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care ? — —
4. Any obvious fever, swollen lymphnodes, jaundice, or other evidence of infection which might spread through the institution ? — —
5. Is the skin in poor condition or show signs of vermin or rashes ? — —
6. Does the inmate appear to be under the influence of Alcohol, or Drugs ? — —
7. Are there any visible signs of Alcohol or Drug withdrawal ? (Extreme perspiration, shakes, nausea, pinpoint pupils etc) — —
8. Is the inmate making any verbal threats to staff or other inmates ? — —
9. Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available ? — —
10. Does the inmate have any obvious physical handicaps ? — —

IF THE ANSWER IS YES TO ANY QUESTIONS FROM 2 to 10 ABOVE - SPECIFY WHY IN SECTION BELOW

11. Are you presently taking medication for diabetes, heart disease, seizure, arthritis, asthma, ulcers, high blood pressure or psychiatric disorder? ✓ —
12. Are you on any special diet prescribed by a physician ? (if yes - what type ?) — —
13. Do you have a history of venereal disease or abnormal discharge ? — —
14. Have you recently been hospitalized or recently seen a medical or psychiatric doctor for any illness ? ✓ —
15. Have you ever attempted suicide ? (If yes - When ? Sept 13, 94 How ? OVER DOSE) — ✓
16. Do you want to do any harm to yourself now ? — —

DEPARTMENT OF CORRECTIONS

EMERGENCY/ (OTHER) TREATMENT RECORD

DATE 10/20/97	TIME 1125 AM	FACILITY Kelby Inmate	<input type="checkbox"/> EMERGENCY <input checked="" type="checkbox"/> OTHER	
ALLERGIES NKA		CONDITION ON ADMISSION <input checked="" type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA		
VITAL SIGNS: TEMP 97.3		ORAL RECTAL	RESP. 20	PULSE 104 B/P 149/90
NATURE OF INJURY OR ILLNESS		ABRASION///	CONTUSION #	BURN ^{xx} / _{xx}
3-CP @ dizziness. HRT occasionally. Throat tight. men. SOB. Stress out & anxiety but never this dizzy. 0- Was scared. Moody for counseling but re- sults stop. Manic depressive dx. NKA A. Anxiety		FRACTURE ^Z / _Z	LACERATION/ SUTURES	
				
ORDERS, MEDICATION, etc.				
DIAGNOSIS				
INSTRUCTIONS TO PATIENT				
RELEASE/TRANSFER DATE	TIME AM PM	RELEASE/TRANSFERRED TO	CONDITION ON DISCHARGE	
		<input checked="" type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE <input type="checkbox"/>	<input type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE	DATE	PHYSICIAN'S SIGNATURE	DATE	CONSULTATION
	10/20/97		10/20/97	
PATIENT'S NAME (LAST, FIRST, MIDDLE)		AGE	DATE OF BIRTH	R/S AIS #
Thomas Barry		31	11/29/66	WM 178628

PROBLEM LIST

Name: Thomas Barry
 AIS# 178628

Date of Birth: 11-20-66

Medication Allergies: NKDA

Mental Health Code: SMI HARM HIST NONE Date Code Assigned: 1-29-02
 (Changes in Mental Health Code should be identified on the Problem List)

Date Identified	Chronic (Long-Term) Problems Roman Numerals for Medical/Surgical Capital Letters for Psychiatric/Behavioral	Date Resolved	Health Care Practitioner Initial
1/19/02	Engaging for unit 1st R		
12/29/02	Correct code <u>HARM</u>		WJL
10/15/02	Constipation		
10/21/02	4th Turn		
7/30/03	<u>HIST</u>	12/23/02	JG
5/10/04	<u>HISTORY</u>		BJ



RELEASE OF RESPONSIBILITY

Inmate's Name: Thomas, BarryDate of Birth: 112066 Social Security No.: AlS 178628Date: 112304 Time: 050 A.M.
P.M.This is to certify that I, thomas, Barry, currently in

(Print Inmate's Name)

custody at the East, am refusing to

(Print Facility's Name)

accept the following treatment/recommendations: Waive CCC - CCC

(Specify in Detail)

Will be deed dt no medication.

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Barry Thomas 178628
(Signature of Inmate)**

RT euh
(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

9A43



RELEASE OF RESPONSIBILITY

Inmate's Name: Thomas Barry

Date of Birth: 11/20/66 Social Security No.: 178628

Date: 08/30/04 Time: 7:00 pm A.M. P.M.

This is to certify that I, Thomas Barry, currently in
(Print Inmate's Name)

custody at the East, am refusing to
(Print Facility's Name)

accept the following treatment/recommendations: cccaypt
(Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Barry R Thomas R Teal
(Signature of Inmate)** (Signature of Medical Person)

(Witness) (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.



PRISON HEALTH SERVICES

NON-COMPLIANCE NOTICE

The following has been observed and documented per non-compliance policy:

CLASS

_____ Diet

_____ Medication

☒ Treatment

SPECIFIC

ADA _____

CARDIOVASCULAR _____

ALT. G.I. _____

OTHER _____

INFECTIOUS _____

ACUTE _____

CHRONIC _____

PSYCHIATRIC _____

OTHER _____

BLOOD PRESSURE _____

DRESSING _____

ACCUCHECK _____

OTHER *acc apt*

ACTION TAKEN BY NURSING:

☒ Counseling

_____ Discontinue Medication

_____ Re-assign Schedule

_____ Placed on sick call

_____ Inform MH Department

_____ M.A.R. Review

ACTION TAKEN BY PRESCRIBERS:

_____ Physician

_____ P.A.

_____ Psychiatrist

_____ Counseling

_____ Discontinue Meds

_____ Discontinue Tx

_____ Change Meds

OTHER _____

ACTION TAKEN BY INMATE:

_____ Treatment Refusal Signed

_____ Explanation of Non-Compliance

_____ Refuses to sign

08304 RTeach Barry Thomas

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	RACE/SEX	FAC.
<i>Thomas, Barry</i>	<i>178628</i>	<i>11/20/66</i>	<i>WM</i>	<i>East</i>

PHS-MD-70057

PRISON HEALTH SERVICES, INC.

HEALTH EVALUATION

I. HISTORY - (LPN or RN)

YES

NO

COMMENT(S)

Weight Change (greater 15 lbs.)

(Compare Weight Below)

Persistent Cough

Chest Pain

Blood in Urine or Stool

Difficult Urination

Other Illnesses (Details)

Smoke, Dip or Chew

ALLERGIES

Weight 180 Temp 97 Pulse 84Resp 20Blood Pressure 102/55Eye Exam: 20/30 OD 20/40 OS 20/100 OU

If greater than > 140/60, repeat in 1 hour.

Refer to M.D. if remains > 140/90.

II. TESTING - (LPN or RN)

RESULTS

Tuberculin Skin Test (q yr)

Past Positive TB Skin Test

(Chest x-ray if clinical symptoms)

RPR (q 3 yrs)

EKG (baseline at 35, over 45 q 3 yrs)

Cholesterol (at 35 then q 5 yrs)

Finger Stick Blood Sugar

* If > than 200 repeat Finger Stick BS within 48 hours

Optometry Exam (@ 50 if not already seen)

Mammogram

(females @ 40, q 2 yrs/other M.D. order)

Date given 5-19-07 Site QFARead on 5-21-07 Results 20 mm

Survey Completed

Date _____ Results _____

Date 5-22-06 Results NR11-27-09 NSR11/29/09 253Results 97

Results _____

Date _____ Results _____

III. PHYSICAL RESULTS - (RN, Mid-Level, M.D.)

Heart

Lungs

Breast Exam

Rectal (yearly after 45)

with Hemoccult

Pelvic and PAP (q 1 yr)

RRRclear, equal bilaterally

Results _____

Results _____

Date _____ Results _____

Facility ELF Nurse Signature [Signature]Date 5-19-07M.D. or Mid-Level Signature [Signature]Date 5/1/07

INMATE NAME

AIS#

D.O.B.

RACE/SEX

Thomas, Barry17862811-20-66W/M



HEALTH EVALUATION

I. HISTORY – (LPN or RN)

	YES	NO	COMMENT(S)
Weight Change (greater 15 lbs.) (Compare Weight Below)		✓	_____
Persistent Cough		✓	_____
Chest Pain		✓	_____
Blood in Urine or Stool		✓	_____
Difficult Urination		✓	_____
Other Illnesses (Details)		✓	_____
Smoke, Dip or Chew		✓	_____
ALLERGIES		✓	NKA

Weight 174# Temp 98° Pulse 76 Resp 16 Blood Pressure 120/84
 Eye Exam: 20/150D 20/50 OS 20/50 OU
 If greater than > 140/90, repeat in 1 hour.
 Refer to M.D. if remains > 140/90.

II. TESTING – (LPN or RN)

	RESULTS
Tuberculin Skin Test (q yr)	Date given <u>5-20-06</u> Site <u>LEA</u>
Past Positive TB Skin Test (Chest x-ray if clinical symptoms)	Read on <u>5/22/06</u> Results <u>0</u> mm
RPR (q 3 yrs)	Survey Completed _____
EKG (baseline at 35, over 45 q 3 yrs)	Date _____ Results _____
Cholesterol (at 35 then q 5 yrs)	Date <u>5-20-06</u> Results <u>penkin</u>
Finger Stick Blood Sugar	<u>11-04</u> <u>11-29-04</u> Results <u>100</u>
* If > than 200 repeat Finger Stick BS within 48 hours	Results _____
Optometry Exam (@ 50 if not already seen)	_____
Mammogram	Date _____ Results _____
(females @ 40, q 2 yrs/other M.D. order)	_____

III. PHYSICAL RESULTS – (RN, Mid-Level, M.D.)

Heart	<u>RRR</u>
Lungs	<u>cl. btl.</u>
Breast Exam	<u>Instructed</u>
Rectal (yearly after 45)	Results <u>N/A</u>
with Hemoccult	Results <u>N/A</u>
Pelvic and PAP (q 1 yr)	Date _____ Results _____

Facility East Nurse Signature Phyllis R Date 5-20-06

M.D. or Mid-Level Signature [Signature] Date 5/22/06

INMATE NAME	AIS#	D.O.B.	RACE/SEX
<u>Thomas B...</u>	<u>178678</u>	<u>11/20/66</u>	<u>W.</u>



YEARLY HEALTH EVALUATION

I. HISTORY – (LPN or RN)	YES	NO	COMMENT(S)
Weight Change (greater 15 lbs.) (Compare Weight Below)	_____	✓	_____
Persistent Cough	_____	✓	_____
Chest Pain	_____	✓	_____
Blood in Urine or Stool	_____	✓	_____
Difficult Urination	_____	✓	_____
Other Illnesses (Details)	_____	✓	_____
Smoke, Dip or Chew	✓	_____	_____
ALLERGIES	_____	✓	_____

Weight 180 Temp 97.8 Pulse 74 Resp 18 Blood Pressure 110/80
 Eye Exam 29/20 OD 29/40 OS 20/50 OU
 If greater than > 140/90, repeat in 1 hour.
 Refer to M.D. if remains > 140/90.

II. TESTING – (LPN or RN)

RESULTS

✓ Tuberculin Skin Test (q yr) Past Positive TB Skin Test (Chest x-ray if clinical symptoms) RPR (q 3 yrs) ✓ EKG (baseline at 35, over 45 q 3 yrs) Cholesterol (at 35 then q 5 yrs) Tetanus/Diphtheria (q 10 yrs) (if done today) Optometry Exam (@ 50 if not already seen) Mammogram (females @ 40, q 2 yrs/other M.D. order)	Date given <u>11/27/04</u> Site <u>LT. FA</u> Read on <u>11/29/04</u> Results <u>0</u> mm Survey Completed Date _____ Results _____ Date <u>7-3-03</u> Results <u>OK</u> _____ _____ Last Given <u>3/00</u> Due _____ Site given _____ Dose _____ Lot # _____ Date <u>11/11</u> Results _____ Date _____ Results _____
---	--

III. PHYSICAL RESULTS – (RN, Mid-Level, M.D.)

Heart	_____
Lungs	_____
Breast Exam	_____
Rectal (yearly after 45) with Hemocult	_____
Pelvic and PAP (q 1 yr)	_____

Facility Eastwin Nurse Signature A. Ewing RN Date 11-27-04
 M.D. or Mid-Level Signature _____ Date _____

INMATE NAME	AIS#	D.O.B.	RACE/SEX
<u>Thomas, Barry</u>	<u>178628</u>	<u>11/20/60</u>	<u>W/M</u>

PERIODIC HEALTH ASSESSMENT

1. HISTORY - (Nurse)

	YES	NO	COMMENTS
Weight Change (>15 lb.) (Compare Weight Below)		<input checked="" type="checkbox"/>	Last Weight at least 6 mo.'s ago: <u>184</u>
Persistent Cough		<input checked="" type="checkbox"/>	
Chest Pain		<input checked="" type="checkbox"/>	
Blood In Urine or Stool		<input checked="" type="checkbox"/>	
Difficult Urination		<input checked="" type="checkbox"/>	
Other Illnesses (Details)		<input checked="" type="checkbox"/>	
Smoke, Dip or Chew		<input checked="" type="checkbox"/>	
ALLERGIES		<input checked="" type="checkbox"/>	

Weight 182 Temp. 98.9 Pulse 72 Resp. 18 B.P. 114/76
 Eye Exam Without Glasses OD 29/50 OS 29/40 OU _____
 With Glasses OD _____ OS _____ OU _____

II. TESTING (Nurse) RESULTS

☒ Tuberculin Skin Test (q yr.) Date Given 3-15-01 Site Lt. arm
 (chest x-ray if clinical symptoms) Read On 3-17-01 Results 0 mm
 RPR (q 3 yrs.) Date 3-14-00 Results NR
☒ Urine Dip (yearly) Results 3-15-01
 (Glu., Prd., RBC., WBC.) Negative
 EKG (baseline at 35, over 45 q 3 yrs.) N/A
 Cholesterol (at 35 then q 5 yrs.) N/A
 Tetanus/Diphtheria (q 10 yrs.) Last Given 9/04 Due 8004
 If Done Today: Site Given N/A Dose N/A Lot # N/A

III. PHYSICAL RESULTS

Heart Regular
 Lungs clear
 Breast (q 2 yrs. p 30) Date 3-15-01 Results negative
 Rectal (yearly p 45) Results N/A
 With Hemocult Results N/A
 Pelvic and PAP (q 1 yr.) Date N/A Results N/A

Inmate Name Thomas, Larry Randall AIS # 178628
 DOB 11-20-66 Age 34 Race W Sex M SSN 423-02-7670
 Emergency Addressee none James Alexander Phone # 272-6870
 Address 11 Astor Drive Montgomery 36109
 Facility KCF Nurse Signature [Signature] Date 3-15-01
 Physician Signature [Signature] Date 3-27-01

KFD11

PERIODIC HEALTH ASSESSMENT

I. HISTORY - (Nurse)

YES NO COMMENTS

Weight Change (>15 lb.)
(Compare Weight Below)Last Weight at least 6 mo.'s
ago: _____

Persistent Cough

Chest Pain

Blood In Urine or Stool

Difficult Urination

Other Illnesses (Details)

Smoke, Dip or Chew

ALLERGIES

Weight 184 Temp. 98.3 Pulse 62 Resp. 16 B.P. 118/84
 Eye Exam _____ Without Glasses OD 20/30 OS 20/30
 With Glasses OD _____ OS _____ OU _____

II. TESTING (Nurse)

RESULTS

Tuberculin Skin Test (q yr.)
(chest x-ray if clinical symptoms)Date Given 3/14/00 Site LT AR
Read On 3/17/00 Results 0 mm

RPR (q 3 yrs.)

Date 3/14/00 Results _____

Urine Dip (yearly)

Results NEG

(Glu., Prd., RBC., WBC.)

Results NEG

EKG (baseline at 35, over 45 q 3 yrs.)

Results N/A

Cholesterol (at 35 then q 5 yrs.)

Results N/A

Tetanus/Diphtheria (q 10 yrs.)

Last Given 9/94 Due 2004

If Done Today:

Site Given _____ Dose 1 Lot # 1

III. PHYSICAL

RESULTS

Heart

Reg

Lungs

Clear

Breast (q 2 yrs. p 30)

Date NA Results _____

Rectal (yearly p 45)

Results N/A

With Hemocult

Results N/A

Pelvic and PAP (q 1 yr.)

Date NA Results _____

Inmate Name Thomas, Barry R. AIS # 178628
 DOB 11/20/64 Age 33 Race W Sex M SSN 423027670
 Emergency Addressee _____ Phone # _____
 Address _____
 Facility Kilby Nurse Signature B. Williams Date 3/14/00
 Physician Signature _____ Date _____

208
CAM

PERIODIC HEALTH ASSESSMENT

I. HISTORY - (Nurse) YES NO COMMENTS

Weight Change (>15 lb.) _____ / _____ Last Weight at least 6 mo.'s ago: _____
 (Compare Weight Below)

Persistent Cough _____ / _____

Chest Pain _____ / _____

Blood In Urine or Stool _____ / _____

Difficult Urination _____ / _____

Other Illnesses (Details) _____ / _____

Smoke, Dip or Chew _____ / _____

ALLERGIES _____ / _____

Weight 180 Temp. 97.8 Pulse 78 Resp. 18 B.P. 120/20
 Eye Exam: Without Glasses OD 20/20 OS 20/20 OU 20/20
 With Glasses OD _____ OS _____ OU _____

II. TESTING - (Nurse) RESULTS

Tuberculin Skin Test (q yr.) Date Given 1/26/99 Site left arm
 (chest x-ray if clinical symptoms) Read On 1/28/99 Results 0 mm
 RPR (q 3 yrs.) Date 12/8/97 Results NR
 Urine Dip (yearly) Results neg
 (Glu., Pro., RBC., WBC.) _____
 EKG (baseline at 35, over 45 q 3 yrs.) _____
 Cholesterol (at 35 then q 5 yrs.) _____
 Tetanus/Diphtheria (q 10 yrs.) Last Given 9/21/94 Due 9/21/2004
 If Done Today: Site Given _____ Dose _____ Lot # _____

III. PHYSICAL RESULTS

Heart off
 Lungs clear

Breast (q 2 yrs. p 30) Date _____ Results _____
 Rectal (yearly p 45) Results _____
 With Hemocult Results _____
 Pelvic and PAP (q 1 yr.) Date _____ Results _____

Inmate Name Thomas Barry AIS # 178628
 DOB 1/20/66 Age _____ Race W Sex M SSN 423-02-7670
 Emergency Addressee _____ Phone # _____
 Address _____
 Facility KCF Nurse Signature Katie Bailey Date 1/26/99
 Physician Signature _____ Date _____

PERIODIC HEALTH ASSESSMENT

I. HISTORY	YES	NO	COMMENTS
WEIGHT CHANGE (>15 LBS.)	—	✓	_____
PERSISTENT COUGH	—	✓	_____
CHEST PAIN	—	✓	_____
BLOOD IN URINE OR STOOL	—	✓	_____
DIFFICULT URINATION	—	✓	_____
ALLERGIES TO MEDS	—	✓	_____
SMOKING	—	✓	_____
OTHER ILLNESS (DETAILS)	—	✓	_____

II. PHYSICAL	RESULTS
HEART	_____
LUNGS	_____
PELVIC AND PAP (q 1 yr.)	DATE _____ RESULTS _____
BREAST (q 2 yrs p 30)	DATE _____ RESULTS _____
WEIGHT <u>184</u> RESP. <u>18</u>	B/P <u>120/70</u> PULSE <u>76</u> TEMP. <u>98.4</u>
RECTAL WITH HEMOCULT (yearly p 45)	_____

III. TESTING	RESULTS
TUBERCULIN SKIN TEST (q yr.)	DATE GIVEN: <u>12/5/97</u> READ: <u>12/8/97</u>
RPR (q 3 yrs.)	RESULTS <u>non</u>
URINE DIP (yearly)	DATE: <u>12/8/97</u> RESULTS: _____
(GLU., PRO., RBC, WBC)	<u>neg</u>
MAMMOGRAM (40 and over q 2 yrs.)	DATE <u>N/A</u>
EKG (baseline at 35, over 45, q 3 yrs)	<u>N/A</u>
CHOLESTEROL (q 5 yrs.)	<u>N/A</u>
TETANUS / DIPHTHERIA (q 10 yrs.)	<u>9/21/94</u>

NURSE'S SIGNATURE Katie Bailey DATE 12/5/97

FACILITY KCF PHYSICIAN'S SIGNATURE TM

EMERGENCY ADDRESSEE _____ TELEPHONE # _____

ADDRESS _____

DOB 11/20/66 AGE 31 RACE W SEX M SSN 423-02-7670

INMATE'S NAME Thomas, Barry AIS# 178628

CM S 155 B

KCB 19

PERIODIC HEALTH ASSESSMENT

I. HISTORY	YES	NO	COMMENTS
WEIGHT CHANGE (>15 LBS.)	—	✓	
PERSISTENT COUGH	—	✓	
CHEST PAIN	—	✓	
BLOOD IN URINE OR STOOL	—	✓	
DIFFICULT URINATION	—	✓	
ALLERGIES TO MEDS	—	✓	
SMOKING	—	✓	
OTHER ILLNESS (DETAILS)	—	—	

II. PHYSICAL	RESULTS
HEART	Normal
LUNGS	Clear
PELVIC AND PAP (q 1 yr.)	DATE NA RESULTS
BREAST (q 2 yrs p 30)	DATE NA RESULTS
WEIGHT 179 RESP. 18	B/P 118/82 PULSE 84 TEMP. 97.6
RECTAL WITH HEMOCULT (yearly p 45)	NA

III. TESTING	RESULTS
TUBERCULIN SKIN TEST (q yr.)	DATE GIVEN: 10-31-96 READ: RESULTS
RPR (q 3 yrs.)	DATE: 9-22-94 RESULTS:
URINE DIP (yearly) (GLU., PRO., RBC, WBC)	10-31-96
MAMMOGRAM (40 and over q 2 yrs.)	DATE NA
EKG (baseline at 35, over 45, q 3 yrs)	2-28-95
CHOLESTEROL (q 5 yrs.)	9-21-94
TETANUS / DIPHTHERIA (q 10 yrs.)	

NURSE'S SIGNATURE [Signature] DATE 10/31/96

FACILITY 1686 PHYSICIAN'S SIGNATURE [Signature]

EMERGENCY ADDRESSEE _____ TELEPHONE # _____

ADDRESS _____

DOB 11/20/66 AGE 30 RACE W SEX M SSN 423-02-7670

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